77-891

In the Supreme Court of the United States

October Term, 1977

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. Emmett Fitzpatrick,
Appellants

vs.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,
Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Jurisdictional Statement

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INDEX TO STATEMENT

Page

JURISDICTIONAL STATEMENT 1

CITATION TO OPINION BELOW 3

JURISDICTION 4

CONSTITUTIONAL PROVISIONS INVOLVED ... 6

STATUTORY PROVISIONS INVOLVED 7

QUESTION PRESENTED 9

STATEMENT OF THE CASE 10

THE QUESTION IS SUBSTANTIAL 13

I. The lower court erred in declaring unconstitutional the mandate of Section 5(a) that requires the physician to protect fetal life when in the physician's "experience, judgment and professional competence...there is sufficient reason to believe that the fetus may be viable" in direct violation of the rights of the viable unborn guaranteed by the Fifth and Ninth Amendments and in violation of the protection which Your Honorable Court granted to the viable unborn in Roe v. Wade, supra, on the erroneous conclusion by the lower court that the safeguard carves out an additional time period of "may be viable" 13

CONCLUSION 14

CERTIFICATE OF SERVICE 15

TABLE OF AUTHORITIES

Page

CONSTITUTIONAL PROVISIONS

Amendment V, U. S. Constitution ..... *Passim*

Amendment IX, U. S. Constitution ..... *Passim*

Amendment XIV, U. S. Constitution..... *Passim*

STATUTES

28 U.S.C. Section 1253 5

28 U.S.C. Section 1342 4

28 U.S.C. Section 2284 5

28 U.S.C. Section 2281 4

42 U.S.C. Section 1983 4

Abortion Control Act, Act No. 209 of 1974, 35 P.S. Section 6601 et. seq. 4 Pa. Leg. Serv. 74, 625 ..... *Passim*

CASES

Doe v. Bolton, 410 U.S. 179 (1973) 9

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 2, 5, 12, 13, 14, 21, 23

Roe v. Wade, 410 U.S. 113 (1973) 2, 5, 9, 13, 14

INDEX TO APPENDIX

Opinion of September 4, 1975 (Relevant portions) 20

Opinion of September 16, 1977 22

Order dated September 16, 1977 25

Notice of Appeal 17

In the Supreme Court of the United States

October Term, 1977
No.

FRANK S. BEAL, Secreatary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, and THE COMMONWEALTH OF PENNSYLVANIA,
Appellants,

vs.

JOHN FRANKLIN, M. D., and OBSTETRICAL SOCIETY OF PHILADELPHIA,
Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Jurisdictional Statement

Appellants, FRANK S. BEAL, Secretary of Welfare, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania and THE COMMONWEALTH OF PENNSYLVANIA bring this direct appeal from a Memorandum Opinion and Order dated September 16, 1977, entered by a statutory three-judge court impaneled by the United States District Court for the Eastern District of Pennsylvania. This order declared unconstitutional, *inter alia*, §5 (a) of the Pennsylvania Abortion Control Act, Act No. 209, 35 P.S. §6601 et seq., and permanently enjoined Pennsylvania's law enforcement officials from enforcement of that section.

The order dated September 16, 1977, was the result of a reconsideration of the court's prior action, as mandated by this Honorable Court. The lower court did not expound on its reason for declaring §5 unconstitutional but merely reaffirmed its prior decision in the September 16, 1977 Memorandum Opinion.

Essentially, §5 (a) of the Abortion Control Act, which clearly echoes this Honorable Courts manifest concern for the unborn child in *Roe v. Wade*, 410 U.S. 113 (1973), and in *Planned Parenthood, et al. v. Danforth, et al.*, 428 U.S. 52(1976), required that prior to the abortion procedure the physician make a determination whether or not the fetus is viable. If the fetus is, or may be, viable, then the physician must use that degree of care which protects the life of the unborn child so long as another method would not be necessitated by a concern for the mothers life or health.

This direct appeal presents a crucial, clear and concise issue and raises a substantial federal question which merits plenary review. There was extensive evidence submitted at the trial of this case which would enable this Honorable Court to review a vital issue with a complete and substantial record. Appellants respectfully request this Honorable Court to permit the filing of briefs and the presentation of oral argument on the question presented.

CITATION TO OPINION BELOW

The September 16, 1977 opinion and order issued by the three-judge court are not officially reported. The opinion and order were filed in the United States District Court for the Eastern District of Pennsylvania at Civil Action No. 74-2440. The September 16, 1977 opinion and order is set forth at length in the accompanying Appendix.

The District Court's opinions of September 4, 1975 are reported at 401 F. Supp. 554 (1975),-jdmt vacated 428 U.S. 901(1976). However, for the convenience of the Court, relevant portions of the September 4, 1975 opinions are contained in the Appendix.

JURISDICTION

(i) On September 20, 1974, Appellees filed a class action complaint invoking Federal jurisdiction pursuant to Title 28 U.S.C. §1342 and Title 42 U.S.C. §1983. The complaint sought declaratory and injunctive relief to restrain Appellants and Appellee Fitzpatrick, District Attorney of Philadelphia County, from enforcing the Pennsylvania Abortion Control Act (Senate Bill 1318). The effective date of the Act was October 10, 1974.

Appellees invoked the Federal Court's jurisdiction to prevent the alleged deprivation of "constitutional rights", including the right of personal privacy, due process and equal protection of the laws as secured by the Fourteenth Amendment to the United States Constitution.

Appellees moved for the convention of a three-judge court pursuant to Title 28 U.S.C. 2281. This motion was granted and the Chief Judge of the Court of Appeals for the Third Circuit appointed a statutory three-judge court composed of the Honorable Arlin M. Adams, Circuit Judge, Clifford Scott Green, District Judge, and Clarence D. Newcomer, District Judge.

On September 20, 1974, Appellees moved for a preliminary injunction and the Court below heard oral argument on October 9, 1974. On October 10, 1974, the Court issued a preliminary injunction, restraining the enforcement of certain provisions of the Act.

On October 12, 1974 Appellants filed an application to vacate the preliminary injunction with Your Honorable Court and said action was assigned No. A-285. Appellants' application was denied by Mr. Justice Brennan on December 19, 1974. On January 13, 1975, your Honorable Court denied the application en Banc.

This case was tried pursuant to Title 28 U.S.C. 2284 from January 13, 1975 through January 17, 1975. The Court below heard final arguments and received additional testimony by way of depositions on March 10, 1975.

On September 4, 1975, the Court below filed opinions and issued an order declaring certain provisions of the Pennsylvania Abortion Control Act to be unconstitutional and permanently enjoined appellants from enforcing those provisions. Appellants appealed to this Honorable Court and by order dated July 6, 1976, the judgments entered by the Court below were vacated and the case remanded for reconsideration in light of *Planned Parenthood v. Danforth, supra*.

(ii) On September 16, 1977, upon consideration on remand, the Court below filed a memorandum opinion and issued an order declaring §5 (a) of the Act unconstitutional and permanently enjoined Appellants from enforcing that provision. Appellant filed a timely notice of appeal to this Honorable Court a copy of which appears in the Appendix.

(iii) Title 28 U.S.C. §1253 confers jurisdiction on this Honorable Court to review by direct appeal an order restraining state officials from enforcing a state statute.

(iv) Appellants assert the following cases sustain this Honorable Court's jurisdiction: *Roe v. Wade*, supra; *Planned Parenthoold of Central Missouri, et al. v. Danforth*, supra.

(v) The Abortion Control Act, Act No. 209 of 1974, is officially reported at 35 P.S. §6601, et seq., and 4 Pa. Leg. Serv. 74, 625. Relevant portions of the Abortions Control Act are set forth in this Jurisdictional Statement in the section entitled "Statutory Provisions Involved".

CONSTITUTIONAL PROVISIONS INVOLVED

Fifth Amendment to the Constitution of the United States:

"No person shall be held to answer to a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation."

Ninth Amendment to the Constitution of the United States:

"The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people."

Fourteenth Amendment to the Constitution of the United States, in pertinent part:

"Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

STATUTORY PROVISIONS INVOLVED[1]

The Pennsylvania Abortion Control Act, P.L. 209 of 1974 (Senate Bill 1318) is set forth as follows:

"Section 1. Short Title.—This act shall be known and may be cited as the 'Abortion Control Act.'

Section 2. Definitions.—As used in this act: 'Department' means the Department of Health of the Commonwealth of Pennsylvania.

'Facility' means a hospital, health care facility, physician's office or other place in which an abortion is performed.

'Informed consent' means a written statement, voluntarily entered into by the person upon whom an abortion is to be performed, whereby she specifically consents thereto. Such consent shall be deemed to be an informed consent only if it affirmatively appears in the written statement signed by the person upon whom the abortion is to be performed (i) that she has been advised that there may be detrimental physical and psychological effects which are not foreseeable, (ii) of possible alternataives to abortion, including childbirth and adoption, and (iii) of the medical procedures to be used. Such statement shall be signed by the physician or by a counselor authorized by him and shall also be made orally in readily understandable terms in so far as practicable.

'Viable' means the capability of a fetus to live outside the mother's womb albeit with artificial aid.

Section 5. Protection of Life of Fetus.

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his

[1]Only the definitional sections of the Act and that section involved in this Appeal are set forth herein.

experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

QUESTION PRESENTED

I. Whether the lower court erred in declaring unconstitutional the mandate of Section 5(a) that requires the physician to protect fetal life (when in the physician's "experience, judgment and professional competence...there is sufficient reason to believe that the fetus may be viable") in direct violation of the rights of the viable unborn guaranteed by the Fifth and Ninth Amendments and of the protection which Your Honorable Court granted to the viable unborn child in *Roe v. Wade*, supra, and *Doe v. Bolton*, 410 U.S. 179 (1973), on the erroneous conclusion by the lower court that the safeguard carves out an additional time period of "may be viable"?

STATEMENT OF THE CASE

The Pennsylvania Abortion Control Act (Senate Bill 1318; Act 209 of 1974) was passed into law on September 10, 1974. The law was to be effective within thirty (30) days, on October 10, 1974.

Appellees filed the class action complaint on September 20, 1974. The Plaintiffs were Planned Parenthood of Southeastern Pennsylvania, a corporation involved in abortion referrals, and John Franklin, M.D., a physician who was designated as a representative of an alleged class composed of all Pennsylvania physicians who perform abortions. Dr. Franklin sought to assert the rights of the physicians as well as those of the physicians' female patients. On September 28, 1974, the Court set the hearing on the motion for a preliminary injunction for October 9, 1974. On October 4, 1974, an amended complaint was filed and, in essence, added Concern for Health Options: Information, Care and Education, Inc. (CHOICE), and Clergy Consultation Service of Northeastern Pennsylvania as Plaintiffs in this action. Both of these organizations operate abortion referral services. On October 9, 1974, after oral argument on the motion for preliminary injunction was completed, the Obstetrical Society of Philadelphia moved to intervene as a Plaintiff and this motion was granted by the Court. By order dated September 4, 1975, the Court granted Appellants' motion to dismiss Planned Parenthood, CHOICE and Clergy Consultation Service as Plaintiffs in this action.[2]

The original complaint named the District Attorney of Philadelphia and the Secretary of Welfare as Defendants.[3]

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[2]Consequently, Planned Parenthood, CHOICE and Clergy Consultation Service have been dropped from the caption of this case and are not listed as Appellees before Your Honorable Court.

[3]At the time this action was commenced, Helene Wohlgemuth was the Secretary of Welfare of Pennsylvania. During the course of this litigation, she was replaced in that position by Frank S. Beal, who is designated as one of the Appellants herein.

The Attorney General of Pennsylvania and the Commonwealth of Pennsylvania intervened as Defendants in this action.

At the hearing on the motion for preliminary injunction, no testimony was taken, no affidavits received into evidence, nor any evidence of any nature offered by the Plaintiffs. However, the three-judge court issued a preliminary injunction on October 10, 1974, which restrained the Appellants from enforcing crucial provisions of the Act.

The trial of this case commenced on January 13, 1975 and continued for five full days, concluding on January 17, 1975. During the trial the Court heard actual testimony from five witnesses for Appellees and eleven witnesses for Appellants. Additionally, the Court received testimony by way of depositions from two additional witnesses and affidavits from an additional four witnesses. The majority of the witnesses called in this action were medical specialists, physicians, psychiatrists or social workers and, therefore elaborate expert testimony was elicited on all aspects of abortion procedures.

Judgment was rendered in this case on September 4, 1975, and the Court declared the Act to be severable and upheld the constitutionality of Section 2's definition of "informed consent", Section 3(a), Section 5(c), Section 6(a), Section 6(c) and Section 8. The lower court declared Section 2's definition of "viable", Section 3 (b) (i), Section 3 (b) (ii), Section 5 (a), Section 6 (b), Section 6 (f) and Section 7 unconstitutional. In its order, the Court ruled that a portion of 6 (d) was constitutional and another portion of that section was unconstitutional.

Appellants in the instant appeal have previously appealed to this Honorable Court in a case styled ***Beal, Secretary of Welfare v. John Franklin, M.D. et al.***, filed at

No. 75-709 October Term, 1975. Likewise, the appellees herein had also appealed those portions of the Statutory Court's judgment adverse to them in a case styled ***Franklin, et al. v. Fitzpatrick District Attorney of Philadelphia, et al.*** filed at No. 75-772. By order dated July 6, 1976, this Court affirmed the lower court's judgment in *Franklin v. Fitzpatrick* (No. 75-772) and vacated the District Court's judgment and remanded the present Appellants appeal (No. 75-709) with the following order:

> "The Judgment is vacated and the case is remanded to the United States District Court for the Eastern District of Pennsylvania for further consideration in light of *Planned Parenthood of Central Missouri v. Danforth*, ___ U.S. ___ (1976); *Singleton vs. Wulff*, ___ U.S. ___ (1976), and *Virginia State Board of Pharmacy v. Virginia Citizen's Consumer Council*, 425 U.S. ___ 1976. Mr. Justice Stewart and Mr. Justice White would note probable jurisdication and set the case for oral argument."

After remand to the lower court, the parties entered into a Stipulation which disposed of all of the remanded issues with the exception of §5 (a), the subject of this appeal, and §7 of the Act relating to governmental subsidy of abortions.[4]

The District Court found that §5 (a) was violative of the United States Constitution in the Memorandum Opinion dated September 16, 1977, a copy of which is contained in the Appendix to this Jurisdictional Statement. Also included in the Appendix is a relevant portion of the Statuory Court's prior opinion relating to §5 (a).

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[4]Appellees have not appealed the Statutory Court's determination that Section 7 was constitutional.

I.

The lower court erred in declaring unconstitutional the mandate of Section 5 (a) that requires the physician to protect fetal life when in the physician's "experience, judgment and professional competence . . . there is sufficient reason to believe that the fetus may be viable" in direct violation of the rights of the viable unborn guaranteed by the Fifth and Ninth Amendments and in violation of the protection which Your Honorable Court granted to the viable unborn in Roe v. Wade, supra, on the erroneous conclusion by the lower court that the safeguard carves out an additional time period of "may be viable".

Section 5 (a) is simply a codification of the *Roe v. Wade*, supra, concept that if an abortion is to be performed after viability, the physician should attempt to preserve the baby's life. This section does not proscribe the performance of abortions, but instead merely puts the physician on notice to consider fetal viability in selecting the abortion *method*. Section 5 (a) requires this particular standard of care only if another method is not contra-indicated for the life or health of the mother. If another method is not so indicated, the Commonwealth asserts that protection of viable fetal life is the compelling state interest described in *Roe v. Wade* and *Planned Parenthood vs. Danforth*, supra.

The lower court erroneously concluded that this standard of care requirement establishes a time period prior to viability during which abortions are prescribed—loosely referred to as the "may be viable" period. This conclusion is clearly unsupported by the evidence and is of no constitutional import since only the abortion method is proscribed and not the performance of the abortion itself. The compelling state interest in the protection of the viable unborn clearly mandates the right of the state to proscribe abortion methods which will endanger the viable child.

CONCLUSION

Appellants submitted at trial extensive evidence concerning the methods of abortion procedures available and their affect on mother and child. There was extensive expert medical testimony concerning the need for medical judgment depending on the circumstances surrounding each pregnancy, a medical view which this Court recognized in *Roe v. Wade*, supra and *Planned Parenthood v. Danforth, et al.*, supra. Appellants submitted that this direct appeal will provide a strong evidentuary basis for an examination of a concise issue relating to viability which would serve as a guide to the state legislative bodies who continue to wrestle with the abortion problem.

Therefore, Appellants respectfully urge this Honorable Court to note jurisdiction in this case and set it for plenary review with briefs and oral arguments on the merits.

Respectfully submitted,

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Attorney for Appellants

CERTIFICATE OF SERVICE

I, the undersigned attorney for Appellants, and a member of the bar of the United States Supreme Court, do hereby certify that pursuant to the Supreme Court Rule No. 33 I have caused to be served true and correct copies of the foregoing Jurisdictional Statement upon each party required to be so served, by depositing said copy in a United States Postal Service mail box, with first class postage prepaid and affixed, addressed as follows:

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD ASSOCIATION OF SOUTH-EASTERN PENNSYLVANIA, INC., et al.,
Plaintiffs
and
OBSTETRICAL SOCIETY OF PHILADELPHIA,
Intervenor Plaintiff
v.
F. EMMETT FITZPATRICK, JR. and FRANK S. BEAL,
Defendants,
and
ROBERT P. KANE and THE COMMONWEALTH OF PENNSYLVANIA,
Intervenor Defendants.

Civil Action No. 74-2400 Class Action

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

TO: THE CLERK OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA:

Pursuant to Rule 10 of the Rules of the Supreme Court of the United States, notice is hereby given that ROBERT P. KANE, FRANK S. BEAL and THE COMMONWEALTH OF PENNSYLVANIA, hereby appeals to the Supreme Court of the United States from that portion of the September 16, 1977, order and final judgment of the Three Judge District Court which permanently enjoined the enforcement of Section 5(a) and Section 5(d) insofar as it

related to Section 5(a) of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P.S Section 7701 et seq.

This appeal is taken pursuant to 28 U.S.C. Section 1233.

J. JEROME MANSMANN
Special Assistant Attorney General
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CERTIFICATE OF SERVICE

I. J. JEROME MANSMANN, ESQUIRE, hereby certify that I have caused a true and correct copy of the within Notice of Appeal to be served on all counsel of record and the Three Judge District Court by depositing same in the United States Mail, first-class postage pre-paid, addressed as follows:

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J. JEROME MANSMANN, ESQUIRE
Special Assistant Attorney General
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601 Grant Street
Pittsburgh, Pennsylvania 15212

OPINION OF THE DISTRICT COURT 9/5/75

• • •

In addition to challenging the definition of viability as being vague, plaintiffs also challenge the right of the legislature to regulate the procedure used where the fetus "may be viable", as evidenced by the language of Section 5(a) and enforced by Section 5(d) of the Act. *Roe* makes it abundantly clear that the compelling point at which a state in the interest of fetal life may regulate, or even prohibit, abortion is not before the 24th week of gestation of the fetus, at which point the Supreme Court recognized the fetus then presumably has the capability of meaningful life outside the mother's womb. Consequently, *Roe* recognizes only two periods concerning fetuses. The period prior to viability, when the state may not regulate in the interest of fetal life, and the period after viability, when it may prohibit altogether or regulate as it sees fit. The "may be viable" provision of Section 5(a) tends to carve out a third period of time of potential viability. Defendants' witness, Dr. Keenan, testified that based upon his interpretation of Act 209, the Act's definition of potential viability occurs at 20 to 26 weeks gestation. (See Tr. 1/17/75, p. 549.) It is clear that in carving out this new time period labeled "may be viable" the state is regulating abortions during the second trimester, when it may lawfully do so only in the interest of maternal health. Yet the state does not claim the provision to be in the interest of maternal health, nor has it shown any connection between this provision concerning fetuses which "may be viable" and maternal health. Clearly, the state seeks to justify this provision only as a measure in furtherance of its claimed interest in protecting potentially viable fetuses. Since this provision does not meet the requirements of *Roe*, we declare it to be unconstitutional.

In reaching our conclusion concerning the issues of viability as defined, and as incorporated in Section 5(a), we

have considered two cases which defendants have cited as upholding similar definitions of viability: *Wolfe v. Schroering*, 388 F. Supp. 631 (W.D. Ky. 1974) and *Planned Parenthood of Central Missouri v. Danforth*, 392 F. Supp. 1363 (E.D. Mo. 1974), *stay grtd.*, 95 S. Ct. 1111 (1974). After examining *Wolfe*, and *Danforth* we are not persuaded by the reasoning of the three-judge courts in either case, but rather we are bound to follow the mandate of the United States Supreme Court in *Roe* and *Doe*. Our decision herein is consistent with the holdings of several other courts. See, for example, *Hodgson v. Anderson*, 378 F.Supp. 1008 (D. Minn 1974), *appeal dismissed*, 95 S. Ct. 819 (1975); and *Leigh v. Olson*, 385 F. Supp. 255 (D. N.D. 1974).

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD ASSOCIATION, et al.,
Plaintiffs
and
OBSTETRICAL SOCIETY OF PHILADELPHIA,
Intervenor Plaintiff
vs.
F. EMMETT FITZPATRICK, JR. and FRANK S. BEAL,
Defendants,
and
ROBERT P. KANE and THE COMMONWEALTH OF PENNSYLVANIA,
Intervenor Defendants.

Civil Action No. 74-2440

MEMORANDUM

Before ADAMS, *Circuit Judge* and NEWCOMER and GREEN, *District Judges.*

(Filed September 16, 1977)

GREEN, *District Judge.*

On September 4, 1975, we filed opinions and an order adjudicating constitutional challenges to specific sections of the Pennsylvania Abortion Control Act (Act)[1]; the parties appealed. The Supreme Court of the United States affirmed the judgment of this Court in regard to plaintiffs' appeal; however, on consideration of defendants' appeal the Supreme Court vacated the judgment entered and remanded to this Court "for further consideration in light of

[1]Act No. 209 of 1974, 35 P.S. §7701, *et seq.*

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. ___ (1976); *Singleton v. Wulff*, 428 U.S. ___ (1976) and *Virginia Citizens Consumer Council*, 425 U.S. ___ (1976)."

We have reconsidered the challenged sections in light of the aforesaid decisions of the Supreme Court and enter an order in compliance therewith. Also, the order entered conforms with the stipulation of the parties, except as it relates to section 5(a) of the Act[2]. Since the parties are unable to agree to the proper resolution of the challenge to section 5(a), they have submitted the issue to the Court, on briefs, for decision.

After reconsideration of section 5(a) in light of the most recent Supreme Court decisions, we adhere to our original view and decision that section 5(a) is unconstitutional[3].

Counsel for the parties have not stipulated as to section 7 of the "Act"[4], electing to have the Court decide the issue after

[2]Section 5 (a) provides:

(a) Every person who performs or induces and abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

[3]Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (1975).

[4]Section 7 provides:

Since it is the public policy of the Commonwealth not to use public funds to pay for unneeded and unnecessary abortions, no abortion shall be subsidized by any State or local governmental agency in the absence of a certificate of a physician, filed with such body, stating that such abortion is necessary in order to preserve the life or health of the mother.

Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations, made by the Commonwealth or a local

(continued)

consideration of the decisions of the U.S. Supreme Court in *Beal v. Doe*, ___ U.S. ___, 97 S.Ct. 2366, ___ L.Ed.2d ___ (1977) and *Maher v. Roe*, ___ U.S. ___, 97 S.Ct. 2376, ___ L.Ed.2d ___ (1977). We declare section 7 does not violate Title XIX of the Social Security Act, *Beal v. Doe, supra;* nor does section 7 violate the Equal Protection Clause of the Fourteenth Amendment, *Maher v. Roe, supra.*

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government agency to hospitals for their maintenance and operation, or, for reimbursement to hospitals for services performed. 1974, Sept. 10, P.L. 639, No. 209, §7, effective in 30 days.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD ASSOCIATION, et al.,
Plaintiffs
and
OBSTETRICAL SOCIETY OF PHILADELPHIA,
Intervenor Plaintiff
vs.
F. EMMETT FITZPATRICK, JR. and FRANK S. BEAL,
Defendants,
and
ROBERT P. KANE and THE COMMONWEALTH OF PENNSYLVANIA,
Intervenor Defendants.

Civil Action No. 74-2440

ORDER

AND NOW to wit this 16th day of September, 1977, upon consideration of the pleadings, evidence, memoranda filed and in consideration of the stipulation and proposed order counsel filed in this action it is hereby ordered, adjudged and decreed:

I. The following sections of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P.S. §6601, *et seq.* are constitutional and enforceable as set forth below:

Section 2, definition of Viable.

Section 5(d) insofar as it relates to Section 5(b)

Section 6(b)

Section 6(d) insofar as it relates to the following

information: the name, address, and age of a woman upon whom the abortion was performed, the date on which the abortion was performed, the date upon which determination of pregnancy was made; the approximate age of the fetus and, if applicable, a full statement of the facts upon which the person performing the abortion relied on establishing that the abortion was necessary for the life and health of the mother and insofar as it requires patients consent to be affixed to the facility statement.

Section 7. Also, we declare that Section 7 does not violate Title XIX of the Social Security Act.

II. The following sections of the Pennsylvania Abortion Control Act are unconstitutional and therefore enjoined:

Section 3(b)(i).

Sectio 3(b)(ii).

The first sentence of section 3(e) as it relates to section 3(b).

Section 5(a).

Section 5(d) insofar as it relates to Section 5(a).

Section 6(d) insofar as it requires records regarding information related to the spouse or parent of the woman upon whom the abortion was performed, and insofar as it requires the spousal and parental consents to be affixed to the facility statement.

Section 6(f) except insofar as it prohibits physicians from advertising and the plaintiffs' action on this aspect of Section 6(f) is dismissed without prejudice to the members of the class as certified by the District Court. Plaintiffs

withdraw any challenge to the prohibition of physicians advertising.

BY THE COURT:

/s/ ARLIN M. ADAMS
ARLIN M. ADAMS
Circuit Judge

/s/ CLARENCE C. NEWCOMER
CLARENCE C. NEWCOMER
District Judge

/s/ CLIFFORD SCOTT GREEN
CLIFFORD SCOTT GREEN
District Judge

APPENDIX

In the Supreme Court of the United States

October Term, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,

Appellants

vs.

JOHN FRANKLIN, M. D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees

On Appeal From the United States District Court for the Eastern District of Pennsylvania

Docketed December 16, 1977

Probable Jurisdiction Noted March 6, 1978

TABLE OF CONTENTS

	PAGE
Relevant Docket Entries	1a
Testimony, Louis Gerstley, III, M. D.	5a
Testimony, John Franklin, M. D.	19a
Testimony, Fred Mecklenburg, M. D.	34a
Testimony, Hope Punnett, Ph D	46a
Testimony, Thomas William Hilgers, M. D.	64a
Testimony, Deposition Extracts	83a
Testimony, William J. Keenan, M. D.	87a
Testimony, Arturo Hervada, M. D.	131a
Deposition of Dr. Andros	140a
Deposition of Dr. Franklin	144a
Defendants' Exhibit W, Affidavit of J. Edward Lynch, M. D.	145a
Defendants' Exhibit X, Affidavit of Edward M. Sullivan, M. D.	147a
Defendants' Exhibit Y, Affidavit of Andrew A. Sullivan, M. D.	148a
Defendants' Exhibit Z, Affidavit of Jerry F. Naples, M. D.	149a
Plaintiffs' Requests for Findings of Fact and Conclusions of Law, and Defendants' Responses	151a
Opinion, District Court, September 4, 1975	154a
Dissenting Opinion, District Court	211a
Concurring and Dissenting Opinion District Court	218a
Concurring Opinion, District Court	232a
Order, September 4, 1975	236a
Memorandum, District Court	239a
Order, September 16, 1977	242a

APPENDIX

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action
No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc. et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

RELEVANT DOCKET ENTRIES

1974	Proceedings	No.
Sept. 20	Complaint filed	1
	* * *	
Sept. 26	Order designating the Hon. Arlin M. Adams, U. S. Circuit Judge and the Hon. Clifford Scott	

Green for hearing and determination of this matter, filed 5

9/27/74 entered and copies mailed

Oct. 3 AMENDED Complaint, filed 6

* * *

1975

Sept. 4 OPINION Green, J. Newcomer, J. with concurring & dissenting opinion Adams Circuit Judge, filed 135

9/5/75 entered and Notice mailed

* * *

Sept. 15 Notice of Appeal of Frank S. Beal, Robert P. Kane and the Commonwealth of Penna. to the Supreme Court of the United States, filed 137

* * *

1976

Aug. 5 Certified copy of Judgment received from the Supreme Court of the United States AFFIRMING the Judgment of the District Court, filed 151

8-5-76 entered and copy to Judge Green

Aug. 6 Certified copy of Judgment received from U. S. Supreme Court of the United States that the Judgment of the U. S. District Court is VACATED with costs and that this cause be, and the same is hereby, remanded to the U. S. District for further consideration etc., filed 152

8-6-76 entered and copy to Judge Green

* * *

1977

Sept. 16 Memorandum, Green and Order Sections of the Penna Abortion Control Act No. 209 of 1974, 35 P.S. §6601 et seq are constitutional and enforceable etc., also, Section 7 does not violate Title XIX Social Security Act, etc., filed. Arlin M. Adams 163

9/19/77 entered & copies mailed. CN., CG Dist.

Oct. 12 NOTICE OF APPEAL OF THE COMMONWEALTH DEFTS TO THE UNITED STATES SUPREME COURT, FILED 164

Oct. 14 NOTICE OF APPEAL OF F. EMMETT FITZPATRICK, JR. TO THE SUPREME COURT OF THE UNITED STATES, FILED 165

TESTIMONY FROM TRANSCRIPT OF RECORD OF PROCEEDINGS BEFORE THE LOWER COURT

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action
No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

Before: HON. ARLIN M. ADAMS, U.S. Court of Appeals for the Third Circuit

HON. CLIFFORD SCOTT GREEN, and HON. CLARENCE C. NEWCOMER, U. S. District Court for the Eastern District of Pennsylvania

TESTIMONY OF LOUIS GERSTLEY, III, M.D., TAKEN JANUARY 13, 1975

* * * *

(p. 26)

BY MR. MORRIS:

Q. Now, Doctor, is there, or are there one or more critical physical abilities which determine viability, with respect to each individual fetus?

A. Yes. Primarily, the maturity of the lung is the primary thing that determines the ability of a fetus to stand on its own outside the mother's womb.

Beyond that, the viability and adaptability of the liver and hematopoetic system.

Q. Now, Dr. Gerstley, with respect to the maturity of lungs, is this factor expressed in terms of the ability of the lungs to inhale or exhale; or the ability of the tissues to inhale or exhale, or both?

A. Both.

Q. Now, I ask you, Doctor, to assume the presence in your office or your operating theatre, of a pregnant woman, and ask you to explain for the Court what steps you take to determine the stage of the fetus and the likelihood of the viability.

(p. 27)

A. This is done, primarily by two methods: We attempt to establish a historical perspective of the patient, based on what we call her last menstrual period—when she had her last menstrual period.

There are two things involved here: One is, was this a normal menstrual period, or was there an episode of bleeding that was not a true menstrual period.

The other thing is to determine by the size of the uterus the estrapulated size of the fetus.

Q. What is the most-used method to determine the size of the fetus?

A. By the manual method. That is, where we place one or two fingers in the vagina, one hand on the abdomen, and takes the uterus between those two hands, and from that we determine, roughly, the physical size of the fetus.

Q. Are there other methods available in some hospitals?

A. Yes. You could have X-ray or ultrasonography, which is a new method that is coming in, where the size of the uterus can be determined by ultrasound techniques.

Q. Doctor, having made such an examination of a woman and ascertained the size of the fetus, is the size of the fetus then related to any particular time period?

A. Generally, yes; but within limits of error of both of these techniques.

Q. What is that time period?

A. Weeks' gestation.

(p. 28)

Q. Now, is it possible, Doctor, to determine with respect to the patient that I have asked you to assume, having made all the diagnostic tests that I have asked you to prescribe, whether or not the fetus in that mother is viable?

A. Only roughly.

Q. When you say "roughly" how do you say "roughly"?

A. Because there are too many variable factors that occur. Every practicing obstetrician/gynecologist knows the fallibility of the patient's last menstrual period.

Patients will have what they consider to be a normal period when, indeed, it was not a normal period. In terms of the fact they may have already been pregnant. I think anybody who's been around long enough has seen a patient come into the hospital with abdominal pains, not realizing that she is a term pregnancy, who has had "regular periods" every month up until that point, and there is amazement at the fact that her abdominal pains are indeed a term pregnancy.

On the other side of the coin, one may skip periods, and the last menstrual period may have occurred at some relatively remote time in some physiologic terms from the actual conception of the fetus.

Q. Doctor, is there any test or method, other than the ones that you have described, which will tell you whether a particular fetus in the uterus is viable or not viable?

A. At the present time I know of only one other test, amnio-synthesis, for what we call the lecitthin/

(p. 29)

sphynogomyelin ratio.

These are two chemical compounds that are in the amneotic fluid, and their certain relationships to their concentration in terms of fetal viability.

However, in terms of this After, this would not be applicable, because these relationships do not usually determine viability until about the 34th or 36th week of pregnancy. Prior to that they would indicate immaturity of the fetus.

Q. Doctor, if you cannot then tell till after the 34th or 36th week whether or not a particular fetus is then

viable, are you able to express it in terms of some probability?

A. Yes, I believe we could.

Q. Can you relate those to weeks of gestation?

A. Yes. This is again open to different opinions. In my opinion, the average commencement of viability occurs at about 24-to-26 weeks' gestation, at the very earliest; and very, very few of the fetuses born at this stage of the pregnancy will survive. It is a matter of one or two percent.

I do not personally believe that a fetus born prior to 24 weeks' of gestation has any reasonable chance of survival.

Q. Doctor, what do you define as a "reasonable chance of survival"?

A. Well, in terms of this: I would like to think that a reasonable chance of survival is at least on terms of five percent, and even by any extropolation you may wish to use, certainly at least two to three percent.

(p. 30)

Q. Have there been reported cases of fetuses surviving at less than 24 weeks?

A. There have been reported cases. The smallest fetus I know of weighed 397 grams, which would have theoretically placed this fetus to about seventeen-to-eighteen weeks' gestation, if one used fetal weight as the sole arbitor of maturity.

* * * *

(p. 32)

Q. Doctor, I ask you to assume that you were instructed to determine, with respect to a given patient, at what point in a pregnancy the fetus might be viable.

I will instruct you, for the purpose of my question, the lower limit beyond which you can say with certainty a fetus was not viable where would you place that period of gestational age?

A. I would have to place it at approximately 24 weeks.

JUDGE ADAMS: Would that be 24 weeks from conception, or 24 weeks from the last menstrual period?

THE WITNESS: The last menstrual period, sir.

Q. Now, given the 24 weeks—

THE WITNESS: Based on an average 28-day cycle.

Q. Given the 24 weeks which you have expressed is your opinion at the lowest point at which the fetus might be viable, and allowing the margin of error you had previously described, what might be the lowest practically determined gestational period at which a fetus might be viable?

A. Well, you'd have to allow two, perhaps under difficult circumstances four weeks. So it could range anywhere say, from 20-to-28 weeks.

JUDGE ADAMS: You say it ranges anywhere from 20-to-28 weeks. That range might be further contingent on the facility present when the fetus is in the uterus.

In other words, where you have more facili-

(p. 33)

ties to support the fetus, you could have a slightly

lower time period, and when you have fewer facilities, you would have to have more?

THE WITNESS: Yes, sir.

Q. Now, Doctor, you have described for the Court your opinion, based on your qualifications, expensive as they are, with respect to viability.

Would you expect all physicians to agree with you on these definitions?

A. No.

Q. Are there medical differences of opinion which are respected differences of opinion?

A. Yes.

Q. Doctor, after approximately the middle of pregnancy, is it as easy and positive to tell the gestational period by the tests you have indicated, as it was during the early part of the pregnancy?

A. No. The further along the pregnancy goes, the more difficult it is as I indicated based on the eventual size of the fetus as determined by its genetic make-up.

In fact, and in part by the, shall we say, the uterine involvement that the fetus finds itself in.

Q. Doctor, at what gestational age would you, in your opinion, notwithstanding other respected medical opinions, would you believe that a fetus has a reasonable chance of survival?

(p. 34)

A. Twenty-four-to-twenty-six weeks at the earliest.

Q. Is that a fifty percent chance?

A. Oh, no, nothing like that. I can guarantee you a cross-the-board that you will not find any doctor who

will tell you that a twenty-four-to-twenty-six week fetus has a fifty percent survival chance.

That does not occur until about the 32nd week, give or take two weeks.

* * * *

(p. 40)

Q. And can you indicate for us, Doctor, what the preferential method is for the performing of second-trimester abortions?

A. By whom?

Q. By you.

A. Saline amnio-infusion.

Q. I detect from your answer some question with respect to the general consensus on this.

Can you describe to me whether there would or would not be disagreement on this?

A. There are differing opinions on this. There are new medications on this, called the prostaglandins, a family of 22 different compounds, of which two have been found useful in second trimester abortions.

These are administered by several routes: intravenously, intramuscularly, into the uterus, into the vagina, will produce abortions.

They do have certain safety factors over the saline.

The reason I do not personally happen to like them is they have side effects on the patient that frequently are uncomfortable.

Secondly, they—they are more likely to require repeated * * *

(p. 41)

Thirdly, in second trimester abortions, there is the much greater incidence of the possibility of the fetus being

born alive after a prostaglandins infusion, than there is with a saline.

Q. Doctor, if you were to conduct a procedure contemplating the delivery of the fetus, and you wished it to be delivered alive in 26 weeks, what procedure would you use?

A. If I were forced to this stage, I would say that I would probably have to try oxytosin induction, which I really no not expect to work at this stage of the game.

It can be forced to work. There is evidence that a very fine physician in Montevideo, in Uruguay, a Dr. Caldeyro Garcia, who has shown that almost anybody can be put into labor with a sufficient amount of oxytosin, over a sufficient period of time, sometimes utilizing very, very high dosages of the medicine than we would normally think of.

However, this can be a prolonged and expensive procedure for the patient. Usually, I would say at this stage of the game, we would usually go if the baby is viable we call it a Caesarian section; if the baby is not viable, we call it a hysterotomy.

Q. Doctor, is that procedure distinct and apart from the oxytosin procedure?

A. Yes, totally.

Q. Is it distinct or not?

A. Totally distinct.

(p. 42)

Q. Now, Doctor, what is a hysterotomy?

A. A hysterotomy is exactly the same as a Caesarian section; it is just being used when the fetus is nonviable.

A Caesarian section includes an incision in the abdomen to the uterus; the taking, generally, of the bladder of the interior wall of the uterus, entering the uterus, making an incision in the uterus, removing the products of conception in the uterus, sewing the uterus back up, reapproximating the bladder, and then closing up the abdominal wall.

Q. Remaining for the moment with hysterotomy, Doctor, could you give us the medical indication or contra-indication of it from the mother's standpoint?

A. Well, the indication for it would be, as I said, it is more immediate and less-expensive and time-consuming to the mother.

The contra-indication to it is that all future children born to this mother, in all probability have to undergo a Caesarian section.

It is open to differing medical opinion, but the great majority of the obstetricians in the country feel, basically, that once the endometril cavity, which is the inside of the uterus, has been entered surgically once, all deliveries thereafter should be done by Caesarian section, because of the possibility of rupture of this scar.

The earlier in pregnancy that you do this, the more likelihood that you are going to have to put the scar up into

(p. 43)

what we call the upper segment of the uterus—the fundus —where the scars are even more likely to rupture.

Q. Doctor, I am going to read to you a statement from a medical text for obstetricians, which I believe you are familiar with, and I am going to ask you whether they describe the general range within which the substantial

part of medical opinion falls with respect to the definition of "viability."

First, Doctor, would it be correct to state that interpretations of the word "viability" have varied between fetuses of 400 grams, about 20 weeks' gestation, and 1,000 grams, about 28 weeks' gestation?

A. Yes.

Q. Would it be correct to state that survival of a fetus under a hundred grams is unusual?

A. Yes.

Q. You have indicated that your particular definition of "viability", in terms of weeks of gestation, might be different by other physicians.

Are the differences in the entire medical community, physician-by-physician, in the application of the term "viability"?

A. I don't quite understand what you mean, sir.

Q. Apart from the fact that some physicians might disagree with your definition of "viability"—

A. Yes.

Q. (Continuing)—assuming a physician took a different

(p. 44)

position, would there be other physicians that disagreed with him?

A. Yes.

* * * *

Cross-Examination

BY MR. MANSMANN:

* * * *

Q. Doctor, at the close of your testimony on direct examination, you had indicated that there is a disagree-

ment among the medical community as to viability; is that correct?

A. Yes—well—yes.

Q. So that I understand it properly, you are saying there is disagreement as to the point of viability, or when a particular fetus may attain viability; is that correct?

A. Yes.

(p. 45)

Q. And not as to the standard definition of viability?

A. No. There is a disagreement, I would believe, as to the standard definition of viability.

Q. Where does that disagreement come in; can you tell me that?

A. Well, it would depend on which definition of viability you are using.

Q. How about your definition of viability?

A. Again, there would be differences of opinion; because some people might feel my definition of viability is not accurate.

Q. Now, your definition of viability fairly closely matches the standard definition of viability, doesn't it?

A. Yes. I do not believe I am an off-beat physician.

Q. And the definition that you have recited to this Court is fairly close to the definition that the Legislature has placed in the Pennsylvania Abortion Control Act; is that correct?

A. No.

Q. The only difference is the words "reasonable ancillary aids"; is that it?

A. Those are my words.

Q. Right.

A. Well, in part, because the Act puts no weeks' gestation on viability. It leaves the interpretation of "viability" up to whoever is interpreting the term "viability".

(p. 46)

Q. In other words, it leaves it up to whoever is interpreting "viability" is that correct?

A. That is correct; be that the physician or the prosecuting district attorney.

Q. I believe the Act says that a physician, based on his medical judgment and experience, determines viability; isn't that right?

A. Yes. But if a district attorney wanted to make a case, he can say that that physician's judgment is not valid.

Q. Right. This is where you are talking about having a potential conflict as to whether or not this particular child or fetus was viable?

A. That is correct.

Q. It is not that the Act, or the definition contained in the Act, is clear; is that right?

A. It is unclear, so it makes it difficult for me to make a medical decision on an unclear statement.

Q. And you had gone through with Mr. Morris what the standard definitions are; is that correct?

A. Yes.

Q. And the—one thing that bothers me, Doctor, is that you had previously stated that gestational age by itself could be misleading; is that correct?

A. Yes—well, gestational age based on what?

Q. Based on the clinical history you obtained from the patient and, perhaps, your own examination—physical examina-

(p. 47)

tion.

A. Yes, it still could be.

Q. If we had an Act that said 24 weeks' gestation, and that's the point of viability, wouldn't that be arbitrary?

A. Yes. But that can be ascertained more clearly by the presented data.

In other words, I would feel more comfortable with some fact like this, where I could state that the patient states here is her last period; the uterine size is such-and-so. This tends to conform more to a fact than a figure.

Now, those things have a reasonable margin of error, too. But they are less subject to error than another definition of viability, which was indicated anywheres from 400-to-1000 grams.

Q. Doctor, you can't use grams alone, can you, Doctor?

A. No. You can't determine that until the fetus is out of the uterus.

Q. And there are nutritional aspects that you have to be concerned about, perhaps, if the mother is a smoker —I am talking about a tobacco smoker—or if the mother had some malnutrition; that is going to have an affect in the baby she is carrying, isn't it?

A. That is correct.

Q. That is going to decrease the weight?

A. Yes, sir. This would be a small-for-date baby; one that is more mature than the size would indicate.

(p. 48)

Q. So, that small-for-date baby may be viable, although of a lower weight than a non-viable baby; is that correct?

A. Right.

* * * *

(p. 54)

Q. So in your report—not your report—the report of your committee, it stated that the majority of those who responded indicated that they would limit abortion to at least 20 weeks?

A. Yes.

Q. 160 members felt that abortion should be carried out—

A. Just a moment. 160, an overwhelming majority of what?

A. Of 197 who felt the abortion should be carried out in hospitals to insure patients' safety; is that correct?

A. Yes.

Q. They had—the Society would have entered gestational age of 20 weeks as the outside limit for abortion; is that correct?

A. I don't know that that necessarily would have been correct. This was just an opinion survey; this was not done for future guidelines.

* * * *

(p. 58)

Redirect Examination

BY MR. MORRIS:

Q. Dr. Gerstley, do you have before you the questionnaire of the Obstetrical Society of Philadelphia, to which Mr. Mansmann referred to in cross-examination?

A. Yes.

Q. I direct your attention to Question 8. Would you read that into the record, please.

A. (Reading) "Who should regulate abortion practice?" is the question.

The answers were divided into three: "(a) State legislature," responses 20; (b) "Federal government," responses 24; (c) "Physicians or hospitals," responses 137.

* * * *

TESTIMONY OF JOHN FRANKLIN, M.D., TAKEN ON JANUARY 14, 1975

* * * *

(p. 7)

BY MR. MORRIS:

Q. Now, Doctor, you have heard the word "viability," have you not?

A. I have.

Q. Would it be fair, in general terms, to describe that as the ability of the fetus to survive outside the mother's womb?

A. Yes.

Q. Might some artificial aid be required in some cases?

A. It might well be to preserve the life of the fetus.

Q. If you are presented with a patient, can you determine whether or not the fetus in that patient is viable?

A. I cannot, in any absolute sense; only in a relative sense.

(p. 8)

I think the best thing I could do is offer some probability of the ability to survive outside the mother's womb.

Q. If the fetus is 16 weeks, could you make an absolute determination?

A. From my present knowledge of medical skills, I would believe no fetus of 16 weeks could survive outside the mother.

Q. What about by extraordinary means?

A. The fetus of 16 weeks has heart-beat, has the ability to attempt to survive. Extraordinary means might prolong the heart-beat. That may, in some opinions, be regarded as viability—but not in mine.

I would feel that the infant has the potential for growth at 16 weeks.

Q. Doctor, if you moved onto 24 weeks, a diagnosed 24-week gestation period, could you determine whether that fetus was or was not viable?

A. I could not.

Q. What is the probability?

A. The probability would be very high that the fetus was not viable.

Q. What would be the order of viability in 24 weeks?

A. It would be 95 percent that it is not viable.

Q. What about 28 weeks, Doctor?

A. Twenty eight weeks is a real probability.

(p. 9)

Q. Is respiration a controlling factor, Doctor?

A. To my knowledge, respiration is the key factor.

Q. Now, Doctor, you have indicated some probability. Would you expect a physician generally to agree with you?

A. I have found in reading opinions about viability that physicians do disagree.

Some physicians feel there is the same degree of life present from conception onward, which is the same as survival outside. I suspect there is disagreement about life in the fetus. There are specialists of neonatalogy that push back the time of gestation, where the infant can survive outside the mother.

I assume that will change as technical skills improve.

Q. Doctor, have you done some embryological experiments which are related to life and viability?

A. Yes. For two years I attempted to grow the rat embryo outside the mother, and came to the conclusion that I was prolonging the death of the rat embryo.

When these were looked over in the microscope, it was a slow dying process. I extended the life by 24-to-28 hours by artificial means, such as oxygen; but I did not feel that I was keeping the embryo alive.

Others were engaged in the same work to keep the rat embryo alive outside the uterus of the mother.

(p. 10)

Q. In the case of the presentation of the human fetus in the 20-to-30 week gestational area, would you expect to find some attempts to perform life for some period of time would be successful?

A. I would suspect that what I was involved in, the rat embryo, would be continued on a more sophisticated level, and the probability would be that it will survive for a long period of time, and this may be called by some artificial viability.

Q. Now, the Act under consideration before this Court provides, in part, in Section 5, that if a fetus may be viable then the method of delivery of method of abor-

tion used shou' be that method that provides the fetus with the best opportunity to survive.

Applying that requirement, what method of delivery would be compelled to be used?

MS. LEADBETTER: Objection, Your Honor. The Statute contains an additional caveat; that this method must be used if this is not dangerous to the mother.

I think that is a very important consideration in the case.

MR. MORRIS: I'd like to rephrase my question, if I may, Your Honor.

JUDGE ADAMS: You may.

(Section 5 of the Act read into the record.)

(p. 11)

I now ask you: what method is available if the fetus may be viable, which would give it the best chance for survival?

A. The best chance would be to turn the fetus, once outside the mother, over to those persons best able to maintain its existence.

The procedure to remove the fetus would be to use the hysterotomy method—the removal from the uterus, passing it over without exposure to gases, and so on, to neonatalogy or research workers, someone seeking to maintain the life of the fetus.

Q. Does a hysterotomy, in your opinion, suggest any medical complications for the mother and, if so, what are they?

A. The medical complications of hysterotomy are largely limited to a surgical procedure, Caesarian section, in which no labor has taken place.

Q. Are you familiar with the procedure involving oxytosin?

A. It is possible to simulate labor by drugs and deliver such a fetus vaginally. But the labor, in my opinion, would be a threat to the baby's existence, and the hysterotomy would maintain the existence of the baby, which is the primary role.

Q. If the determination that hysterotomy is detrimental to the life or health of the mother, in the sense it could not be used, would there be any procedure available which would give the fetus the best chance of survival?

(p. 12)

A. The hysterotomy, drug-induced labor, would be the best possible way to getting the baby with the heartbeat.

Q. In other words, your method of choice would be hysterotomy, under those circumstances?

A. That's right.

* * * *

BY MR. MANSMANN:

(p. 17)

Q. Now, Doctor, you also said yo: expect other physicians to disagree as to when a particular fetus has attained viability; is that correct?

A. The definition appears logical, but the application appears different.

Q. Your complaint is that there is a potential disagreement among physicians concerning the application of this particular provision of the Act?

A. The lawsuit in Boston is a case in point; physicians disagree about the viability of 21-to-24 week fetuses.

Q. Twenty four-week fetuses you gave a 5 percent chance of survival; is that correct?

A. Yes. I think that is optimistic.

Q. You set viability at 28 weeks?

A. Yes.

Q. I assume, as the gestational age increases and the weight increases, there is a better chance of survival?

A. Yes.

Q. And this is based on your experience?

A. This is based on tables compiled on the 28-week fetus, judged by others at other institutions.

(p. 18)

Q. So perhaps one 26-week fetus will not be viable and another 26-week fetus perhaps would be viable?

A. That's right.

Q. So that is why you have to judge each case individually?

A. That's right. We cannot judge prior to delivery except to arrive at some probability that I believe the mother is 26 or 28 or 24 weeks.

Q. I think this is some area of confusion. You have talked about disagreement, philosophical disagreement, as to when life begins.

A. Yes.

Q. So some physicians think life begins at conception and others think it begins at delivery?

A. (Indicating)

Q. And some perhaps—

MR. MORRIS: You will have to answer orally, Doctor.

A. Yes.

Q. And some think life begins after the neonatal period of 28 days; is that right?

A. I am not aware of anyone maintaining that definition.

Q. So that life and viabiliy are two different things; you do agree?

A. I agree.

Q. While there may be potential life from conception forward,

(p. 19)

do you agree that there is a point in which viability is reached prior to delivery?

A. I agree with that.

Q. And that there is a definition between viability and life?

A. I agree with that.

Q. The philosophical inferences you were talking about were relating to life rather than viability?

A. I agree with that.

* * * *

(p. 24)

BY MS. LEADBETTER:

Q. Dr. Franklin, let me see if I understand what you have said so far in one area: You have said that at the point of 28 weeks you would consider a fetus normally to be viable; is that correct?

A. That is right, that it has a reasonable chance of survival.

Q. Prior to 24 weeks you would not consider it to be at all viable; is that correct?

A. It all implies probability; a very high probability it will not survive.

Q. In the period between 24 and 28 weeks you have a gray area where the fetus may be viable, depending on different circum-

(p. 25)

stances?

A. That is correct.

MR. MORRIS: I object to that phrasing of the question. I don't think that is what the witness said.

JUDGE ADAMS: Sustained. That was not the testimony.

Rephrase the question.

MS. LEADBETTER: All right.

BY MRS. LEADBETTER:

Q. And there is some increasing degree of viability or survival of the fetus in that area, between 24 and 28 weeks; is that what you said?

A. That is my impression.

Q. Concentrating on this period between 24 and 28 weeks that you have delineated for us, you have said that the greatest likelihood to preserve fetal life would be hysterotomy; is that correct?

A. That is correct.

Q. What method of anesthesia would you use on the mother for the hysterotomy?

A. It probably makes little difference as to which

type of anesthesia is going to be used, based on what I know.

I have not been in the situation, so it is purely hypothetical.

Q. Ordinarily, with a hysterotomy procedure you use a general

(p. 26)

anesthesia rather than local?

A. There are alternatives to those two choices: regional anesthesia in the form of spinal or epidural is another alternative.

Q. If you did not use a general anesthesia, that would reduce the risk of the procedure; wouldn't it?

A. I have no data for concluding this. It might seem so on a theoretical basis; but I know of no data.

Q. Now, is it possible for you to quantify generally the difference in the risk to the fetus of hysterotomy procedure and the procedure using a combination of prostaglandins and oxytocins?

A. No. I have almost no experience with trying to induce labor at that stage with oxytocin.

The literature says it is difficult and may take several days. The claims with prostaglandins are that they are more effective so that you can reduce days to hours, 48 to 72 hours.

I have had no experience with these, with the use of prostaglandins.

Q. So you have no experience with this procedure at all?

A. With attempting to induce an abortion by oxytocin or prostaglandins.

The usual procedure of inducing abortion around 24 weeks is to use saline, saline salt, which is fatal

(p. 27)

to the fetus.

Q. But the method of prostaglandins is beginning to be used?

A. Nowhere near the frequency that saline is used, in my opinion.

Q. That is not my question. It is beginning to be used?

A. That is correct.

Q. And although the replacement of amnionic fluid with the saline solution will almost certainly kill the baby, the infusion of prostaglandins will not have that effect?

A. I have no information on what the—how many of those fetuses would be born without a heartbeat.

Q. That is not my question.

My question is, prostaglandins stimulate uterine contraction rather than kill the child; is that correct?

A. That is correct.

Q. You have testified that the method of hysterotomy has certain effects on the mother, including the necessity for future Caesarian births if the mother wishes to have a child at some future date; is that correct?

A. That is not an absolutely necessity, but it might be considered by many physicians to be the safer route of delivery.

Q. Now, including the probability that future childbirths will be by Caesarian, can you tell us the additional risk to maternal health by using the hysterotomy procedure rather than a saline or prostaglandin induced vaginal abortion?

(p. 28)

A. Not in terms of mortality figures. The risk is not great.

Q. My question, Dr. Franklin, is not as to risk of death of the mother, but as to the preservation of health of the mother.

A. The risk to the mother's health is not great.

Q. You are saying that the risk of health to the mother in the hysterotomy procedure is not great?

A. That's right.

* * * *

(p. 29)

BY MR. MORRIS:

Q. Dr. Franklin, are there reputable and respected physicians who would be of the opinion that a 21-week fetus delivered by a hysterotomy might be viable?

A. I believe there are.

* * * *

(p. 30)

BY MR. MORRIS:

Q. Doctor, is there a possibility of such testimony or probability of physicians so testifying a probability which might inhibit your conduct?

A. Yes, indeed.

MR. MORRIS: That's all, sir. Thank you.

Recross-Examination

BY MR. MANSMANN:

Q. Doctor, you have never done a prostaglandin abortion; is that correct?

A. That is correct.

Q. You really don't know that much about them; is that correct?

A. That's right.

Q. But you do know they are not as life threatening to the

(p. 31)

woman as a saline abortion, for example?—life threatening.

A. To the mother?

Q. Right.

A. Yes. I would answer that is true.

Q. They are not life threatening?

A. They are less life threatening than a saline abortion.

Q. You have been concerned about other physicians apparently testifying against you or some other physician. Who are the physicians that you are concerned about testifying against you?

A. I am not sure I understand the question.

Q. You said that you know that there are reputable physicians who would have a differing opinion from you, and your concern is that they may testify against not you necessarily but some other physician who performed an abortion on a 23, 24-week, 21-week fetus.

A. That's right.

Q. Can you tell me who they are?

A. Not by name. I cannot tell you physicians by name or even category. I know that there are physicians who are outspoken on this subject.

The most recent concrete example I can give you is that recently there was a neonatologist in the City of Philadelphia who felt that the task was to try to maintain the

existence of a 20 or 22 or 24-week fetus, no expense spared, with whatever techniques known to medicine.

(p. 32)

Q. That is his responsibility, the care of the premature or immature infant; is that correct?

A. That's right. But I believe that some neonatologists may pursue their duty of care to limit it to those infants where there is a good probability of a normal existence later, that they might make some choices as to which fetuses or infants they are going to pursue with the most concern.

Q. Can you tell me then their names again, please, the neonatologists that you are concerned about?

A. Yes. The physician who I believe would have sought to maintain the life of a very young fetus was Dr. Mary Louise Soengten.

Q. Now, you are saying that you attempt to maintain life of a premature—

A. Immature is the word I would use.

Q. —immature fetus; is that correct?

A. That's right.

Q. And her specialty is neonatology?

A. That's right.

Q. So I understand you properly, if a 21-week baby is delivered or a live birth resulting from an abortion, she would have the responsibility of attempting to keep this child alive; is that right?

MR. MORRIS: I am going to object. I think in getting to what she would do we are getting a little

(p. 33)

speculative.

The thrust of my questioning involved what his mental and psychological concerns were with respect to what generally might happen. If we are acting with respect to one doctor, I think we are a bit speculative as to this witness.

BY JUDGE ADAMS:

Q. Do you have any knowledge as to what this physician would do or might do? Do you know enough about her professional operations to express an opinion?

A. I worked with this neonatologist for three years. So I have some knowledge.

JUDGE ADAMS: We will allow the question if he can answer it.

BY MR. MANSMANN:

Q. You are saying that she would attempt to use all efforts to keep this child alive?

A. Yes.

Q. And that is her profession?

A. That is how she saw her responsibility, as I understand it from observing her.

Q. So that your concern is that she would come in and testify against a physician; is that right?

A. As I understand what we are talking about, the statute says that you have to do the procedure that gives the fetus the best chance of survival.

(p. 34)

Such a person as Dr. Soengten, could in my opinion, be willing to say that a saline procedure was not the right

procedure for the termination of that pregnancy, and that she would like to have a 20 or 21-week fetus try to maintain its life. And that might be how she saw her task as a neonatologist.

Q. So that it is her discharging of her professional responsibility as a neonatologist which color her opinion; is that what you are saying?

A. That is how she saw her responsibility as a neonatologist, to not have an arbitrary decision that we would not try to save a baby younger than 24 weeks, but to try to save anything that might be saved, that this is the way the barriers will be raised or lowered—I guess lowered for maintaining or saving the lives of very young immature babies.

Q. It is not your opinion that you as a physician or Dr. Soengten should attempt to save the life of the child who can be saved?

A. I didn't say that. My opinion is that if the woman is seeking a termination of a pregnancy that I should be permitted to terminate her pregnancy.

I should not be required by the State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus.

(p. 35)

Q. So it is the vast sum of money, is that your concern?

A. It certainly enters into it.

MR. MANSMANN: That's all I have.

BY MS. LEADBETTER:

Q. Doctor, you wouldn't go to that extent and spend those vast sums of money you were talking about to save

the life of a 20-week fetus who was spontaneously aborted as the mother wanted, would you?

A. Would I?

Q. Yes.

A. This is a decision that comes up quite often in my practice and experience. I find it very difficult.

Q. Have you ever done that?

A. Yes, indeed.

Q. Spent vast sums of money to save—

A. No. I have sent immature fetuses to the neonatologist saying this is a desired pregnancy, the mother has passed the fetus and she was hopeful of carrying it, and the fetus has a heartbeat for several hours.

Q. Has one of those fetuses ever survived?

A. Not to my knowledge.

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TESTIMONY OF FRED MECKLENBURG, M.D.,
TAKEN JANUARY 14, 1975

* * * *

(p. 38)

BY MR. MANSMANN:

Q. Doctor, would you explain to the Court what another method of abortion is which is known as a D&C?

First of all, what do those initials stand for?

A. The term D&C refers to dilation of the cervix and curettage, which is a French word meaning to scrape. Both terms are French.

It applies in abortion to the situation when the uterus is forcibly opened by stretching it and gradually inserting increasing size metal instrument, called a curet introduced—

Q. Could you describe what a curet is?

A. A curet is a loop shaped instrument with a sharp edge that is used like a hoe might be used to loosen the soil of a garden. It is used to scrape the lining and contents of the uterus out.

A more popular method of this at the same point involves using suction rather than curets.

Q. Is the same procedure utilized at least initially in a suction abortion as would be in a D&C as you have previously

(p. 39)

described?

A. Yes. The dilators are used identically the same. The mouth of the uterus is forcibly opened by passing larger dilators. Instead of introducing the curet a larger diameter tube is introduced, and a very powerful suction amounting to several times the atmosphere of the earth is used. This disrupts the pregnancy, usually reducing the content at this early stage. It is reduced to the consistency of crankcase oil.

Q. This is done through the evacuation machinery; is that correct?

A. Right. It is simply the exposure of the very intense pressure that does this.

Most doctors who use suction as a means of abortion also use a curet to be sure that the tissue has all been removed.

(p. 40)

BY MR. MANSMANN:

Q. Doctor, what was the reason where there would be concern that all the placenta tissue has been removed?

A. In most cases all tissues not removed, there is an increased risk of hemorrhage to the woman.

Q. Doctor, we have heard some testimony about an abortion called a "saline-infusion" abortion. Would you please explain that procedure?

A. A saline-infusion abortion is usually used later in the pregnancy, whereby a needle is inserted through the mother's abdominal wall and into the uterus, and a quantity of the amniotic fluid is generally removed for safety reasons.

Q. What would be the danger of injecting more fluid than that which is removed?

A. If the concentrated saline is removed without amniotic fluid, it increases the chance for hemorrhaging. This solution would escape through the abdominal wall of the woman, and it is important to remove the fluid, at least as much as you intend to inject of the saline.

Q. How is the abortion performed, or how would the saline-infusion effectuate or cause abortion?

A. That is something that is not clearly understood. We do know for sure that the saline almost invariably kills the baby.

Most mothers report the traumatic thrashing about and increased movement of the child, and then there is

(p. 41)

movement. We think what happens is that there is a very delicate shift of sodium ions from within the cells of the uterus to extracellular space. In that case the uterus begins to be irritable and starts to crack.

Q. Is the fetus then expelled immediately?

A. Generally there is a latent period. It varies from patient to patient.

Usually the latent period would be twelve to twenty-four hours. When labor does start it is generally fairly rapid, and generally less painful than one would expect.

Q. Would that be a period of 48 hours before the fetus is expelled?

A. 48 hours, yes.

Q. That would be, obviously, vaginally?

A. Yes.

Q. Would that be the simulated type of delivery, had the woman carried to term?

A. There is some experience that would suggest, although not exactly, the same as actual labor. There very often numerous cases report it following the saline infusion, that the cervix had failed to dilate, and the woman seemed to be in natural labor, but in some ways different.

Q. There is, Doctor, another procedure called the prostaglandin infusion. Is it similar to the saline infusion?

(p. 42)

A. In several different ways, yes.

Q. Will you tell the Court in which ways, Doctor?

A. They can be given to the patient intravenously. Very high incidents of severe headaches, diarrhea, nausea occurs, and also the uterus dilates and also results in the expulsion. Few people are using it that way.

It can also go directly into the uterus. It works in a similar fashion, except that it does not kill the baby. The side effects seem to be less severe, but similar. That is, headaches, nausea and vomiting do occur, but with less severity. That is called extra-embryotic. This is similar to the saline infusion, but in many ways it is different.

Q. Doctor, you talked about side effects. Are there side effects in the saline abortion?

A. Yes. There are very big ones. This has been a great deal of concern to many of us. The clotting mechanism of the person in a saline abortion is influenced 100 percent of the time.

In saline abortions, many of these women don't hemorrhage. The clot mechanism is interfered with. Some of these are very severe, and deaths have occurred. If the saline ends up getting into the mother's bloodstream or outside the uterus into the mother's abdominal wall, each of these are hazardous and lives have been lost because of this.

(p. 43)

Q. Doctor, are there side effects similar to the prostaglandin effects you described in the saline abortion?

A. No. We don't see the nausea, headaches, diarrhea and vomiting.

Q. So that the side effects you are talking about is associated with prostaglandin, the headaches?

A. The heart rate and the blood pressure; they are all side effects of prostaglandin.

At a conference of the American Association of Planned Parenthood, in Kansas City, Dr. Bengston discussed the sum total of side effects as being physiological. He was very apprehensive about the total body organization.

Q. Doctor, you are a member of the Association of the Planned Parenthood Physicians; is that correct?

A. Yes, I am.

(p. 44)

Q. And another procedure, would that be the hysterotomy procedure?

A. Yes.

Q. Would you describe that for the Court, please?

A. Well, as Dr. Franklin described it a short time ago, it is a miniature Caesarean section. It involves a regional or general anesthetic; it involves an incision in the abdominal wall, and the fetus is then removed from the mother's placenta, and it is then repaired in the same manner as the Caesarean section.

Q. Could you tell the Court in which gestational age these particular abortions are normally utilized?

A. Only very early in pregnancy, those people that described the procedure in the literature, suggested that it never be used after the patient is 8 weeks from the first day of the last menstrual period, and 6 weeks from conception.

It usually would be confined to patients who are 7 weeks or less.

Q. How about a D & C or dilation and evacuation?

A. Either of these procedures can be used up to 12 weeks.

Q. Are you talking about 8-to-12 weeks?

A. Yes. There are very few doctors that want to do it between 8 and 12 weeks.

Q. Can you tell us the reason for that, Doctor?

A. Well, it is hard to do it with safety, and it is difficult

(p. 45)

to do a D & C or a D & E.

Q. Why?

A. Well, the baby is getting large enough for the skeletal system to form. The skeleton is getting dense enough for the bones to start forming, and it involves a

considerable hazard to try and extract bone from the mother's womb.

Q. Between the 12th and 16th week of gestation, generally there would not be abortion performed?

A. Those doctors that utilize prostaglandins use them during this period mostly. Doctors would prefer not to do it during the period from 12-to-16 weeks.

Q. Now, after 16 weeks, what method is used, Doctor?

A. It can be used after it is safe to get into the amniotic cast. Doctors that do late abortions do utilize saline.

Doctors after 20 weeks are reluctant to use saline. Most of us that do any significant number of deliveries are reluctant to do it. The hysterotomy then enters where the doctor is concerned for the safety of a viable child.

There are patients where saline is very risky. The patient might have had extensive abdominal surgery, and it would cause excessive bleeding in these patients. In these cases, the fetus might be extracted by hysterotomy rather than saline.

Q. The hysterotomy might be used in generally what gestational age?

(p. 46)

A. Probably in common practice, after 24 weeks.

Q. After 24 weeks on?

A. Yes.

Q. In some point that becomes a C-section, and is no longer designated a hysterotomy?

A. Technically, it's a C-section; but all along it is the procedure when it is called a hysterotomy.

Q. Doctor Franklin called it a miniature C-section. He was accurate, in other words?

A. Yes.

Q. Can you tell us what risks are inherent in the various procedures; the risks to the woman undergoing the abortion? Let us take menstrual extraction.

A. That is classified into two general areas: infection and hemorrhage.

Both of these are most often associated with incomplete evacuation of the uterus. There is a possibility that it would push bacteria into the uterine area where infection can ensue.

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(p. 48)

Q. The safest period, as far as maternal health is concerned, would be what gestational age?

A. To break it down, during the first 8 to 9 weeks is the safest time.

Q. Would you put 8 to 12 weeks?

A. Most doctors like to work from the 8th to 12th week.

Q. This is where the D & C or D & E are concerned?

A. Yes.

Q. What risks are inherent as far as the D & C is concerned?

A. The risks of perforating the uterus, or damaging the uterus, and the pregnant uterus is quite soft.

The second risk is the risk of hemorrhage; and the third is the risk of infection.

The data on complications does seem to vary according to the skill and experience of the operator. It varies not only from institution to institution within the United States, but more significant is the experience in this country to the experience of other countries. I am disturbed by the difference.

Q. What risks are inherent in the saline infusion, the risks to the maternal health?

(p. 49)

A. The damage would be that the bowel would be perforated; the risk of hemorrhage would be great, of lacerating vital areas; there is the risk of infection, where the needle might introduce bacteria.

The risk of the saline getting out of the uterus into the peritoneal gland causing saline intoxication.

Q. What would the effect be?

A. Besides overwhelming thirst, the person would become comatose. If the salt gets into the blood cell, it can cause hemolysis of the blood.

I think the principal risk of the saline abortion is the effect it has on the blood-clotting.

Q. Now, Doctor, you described that as one of the side effects; is that correct?

A. Yes; and also the risk of injury to the cervix causing the laceration.

Q. The saline-infusion abortion, is that a life-threatening procedure to the mother?

A. Yes, it can be.

Q. For the reasons that you have previously described about the installation of the saline solution into the maternal system rather than the fetal system?

A. I again refer to the material which was sumitted, where there were six deaths, but one occurred in the late trimester; three were associated with saline and three with hysterotomy.

(p. 50)

Q. And the hysterotomy, are there risks attendant in undergoing hysterotomy?

A. There are risks attendant to any operative procedure that involves anesthesia and incising the tissue.

Q. Would these be the same risks involved in any type of procedure?

A. Yes.

Q. Is general anesthesia administered?

A. It varies from hospital to hospital. It is usually regional and general anesthesia, depending upon the mother's health.

Q. Is saline infusion usually done with a local or general anesthesia?

A. It is generally one wheel of skin injected with novocain.

Q. There would be no general anesthetic given?

A. No.

Q. What about prostaglandin?

A. If it's prostaglandin the small area of skin is injected with novocain.

Q. What about if it is injected vaginally?

A. In that case no anesthesia at all.

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(p. 74)

BY MR. MORRIS:

Q. Doctor, would it be fair to say that it is or a doctor about to treat a woman who is pregnant in the 20th to 28th-week period is a very difficult if not impossible determination to make to decide whether or not the fetus within that woman is or may be viable?

A. It is very difficult.

Q. Almost impossible, is it not?

A. Again, it is—there are probabilities. You can feel by examining the patient within a matter of three to four weeks what the state of gestation is.

Q. From that a lack of probability or probability of survival?

A. Yes.

Q. But impossible as to the specific fetus involved?

(p. 75)

A. That is correct.

In fact, I would agree with Dr. Franklin's testimony in that regard.

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(p. 82)

BY MR. MORRIS:

Q. Doc , as one who performs abortions I want to read you a sentence and ask you what it means to you. The sentence is, "Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid."

I want to ask you at what stage of gestation you as one who has performed abortions would put that definition?

MR. MANSMANN: I have to object and ask that be qualified as to whether or not he thinks that the doctor testified he performed abortions.

MR. MORRIS: I am not assuming he does it for whatever reasons he believes just. I want to ask him what viability means to him in terms of aid.

A. I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact that it is constantly changing.

My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks—not in the current edition of Eastman's Obstetrics book, but in the previous edition, the earliest report a survivor was reported as a delivery at 20 weeks

(p. 83)

gestation.

In my own experience I have—the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal.

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TESTIMONY OF DR. HOPE PUNNETT, TAKEN JANUARY 14, 1975

(p. 85)

MS. WALLIS: Dr. Punnett, please.

MR. MANSMANN: Your Honor, before we begin I request from plaintiffs' counsel an offer of proof as to this particular witness.

JUDGE ADAMS: Yes. Do you mind telling counsel what you hope to prove through this witness?

MS. WALLIS: Your Honor, we hope to prove by this witness that genetic counseling which, in some cases, involves abortion that has to be done between the 20th and 24th weeks of gestation, and consequently an interpretation of the state statute which would prohibit abortion after 20 weeks would foreclose this option.

JUDGE ADAMS: Do you object?

MR. MANSMANN: Yes, Your Honor. I don't believe that there is any evidence admitted that would place the child at 20-to-24 weeks.

There has been some testimony by the plaintiff that viability may occur at 24 weeks, and that was by Dr. Gerstley.

If that is so, the United States Supreme Court

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(p. 86)

this Court from considering that. From the point of viability onward, the State has a compelling interest to prohibit abortion.

It would be legally inappropriate for this Court to make a consideration of that issue.

I do question the witness's ability to testify as to whether or not the abortion can be performed.

JUDGE ADAMS: We will deny the objection at this time.

We will give you the option to move to strike at the appropriate time.

MR. MANSMANN: Yes, sir.

DR. HOPE PUNNETT, called as a witness in behalf of the plaintiffs herein, after first being duly sworn by the Clerk of the Court, testified as follows:

Direct Examination

BY MISS WALLIS:

Q. Dr. Punnett, your qualifications have already been offered.

Is the resume you gave me still current; have there been any changes?

A. No.

Q. In addition to teaching at Temple University, you are also at Saint Christopher's Hospital; is that correct?

A. Yes.

Q. What are your responbilities there?

(p. 87)

A. I am head of the division of genetics within the hospital, the running of the laboratory for testing of certain genetic diseases; for seeing and examining patients for possible and known genetic diseases; for counseling the parents as to any known genetic diseases they may question in themselves, relatives or other off-spring.

Q. Now, Dr. Punnett, would you please describe genetic counseling?

A. It is a communication process whereby we not only give the specific scientific facts as to any individual concerned about a disease, but offer them the many different ways we can be of service, whether it be the placing of a child or discussing the various options that are open to them in relationship to their possible appropriation.

Q. Now, Dr. Punnett, I am showing you a publication called "Birth Defects," reprint series. Will you identify it, please?

(Handing pamphlet to witness.)

A. This is a scientific study published in 1970. The basic facts in it are a discussion as to how prenatal diagnoses are carried; the early studies and discussion of ge-

netic diseases that could be or have been diagnosed prenatally.

Q. Dr. Punnett, there is some handwritten notes in this exhibit. Could you identify those notes, please?

A. Those were my notes which were in an attempt to keep the article up to date and current with scientific knowledge.

(p. 88)

Q. Is the information in that exhibit correct?

A. Yes. There may be some places where causes of disease were not known but since have been known diseases, which were theoretically diagnosable, and the knowledge was not forthcoming at the time the article was written.

MS. WALLIS: Your Honor, I move into evidence this exhibit.

JUDGE ADAMS: Any objections?

MS. LEADBETTER: I have not had a chance to see the document, Your Honor.

JUDGE ADAMS: Then you will reserve any objection you may have to the exhibit.

MS. LEADBETTER: Yes, Your Honor.

MR. MANSMANN: I have no objection to the witness testifying, or this exhibit going into evidence with this caveat: that this should be treated as every other medical text we have submitted to the Court.

However, we are not agreeing to the truthfulness of the items submitted in that document.

JUDGE ADAMS: If you wish an opportunity to look at it, we will give you that opportunity.

MS. LEADBETTER: Thank you, Your Honor.

JUDGE GREEN: I am trying to determine what Exhibit 6 would be.

MR. MORRIS: Your Honor, Exhibit 6, which I

(p. 89)

marked, is a booklet in which appeared articles by a Dr. Meklenburg and Dr. Kravin, among others. I have not yet offered it.

JUDGE ADAMS: For what purpose are you offering Exhibit 7?

MS. WALLIS: For the purpose, Your Honor, of guiding Dr. Punnett's testimony.

The exhibit sets out the basic conditions and type of conditions that can be identified through genetic counseling.

JUDGE ADAMS: When you use it, you understand there was one objection being held in abeyance.

MS. WALLIS: Yes, Your Honor.

(Pamphlet marked Plaintiffs' Exhibit 7.)

BY MS. WALLIS:

Q. Doctor, would you give us examples of the type of genetic disorders that would be diagnosed?

A. There are two good examples, and they are probably tay-sachs disease. This is an auto-somal disease.

This means that two perfectly normal parents are each carriers of a gene for normal development of a particular enzyme; and also a gene that does not act at all.

The children that would come from these parents are born perfect children, and then six months after they are born they begin deteriorating. By the age of three

(p. 90)

they have lost all function; they can't feed themselves. In effect, they become a vegetable.

Then they are put into custodial care between that time and the time they die. It is now possible to recognize that two individuals married to each other who can have such a child.

When that is known, amniotic fluid in this case is simply removed, and nothing is replaced. That fluid can then be grown. There are cells which come from the fetus.

When enough cells are grown these can be analyzed to find out whether the child is lacking the enzyme. If the child is lacking the enzyme it is doomed to death before he is 7 or 8 years old.

In cases like that that child can be aborted from the mother at this point in the pregnancy, and the parents and the child are saved the agony of a slow and painful death, which is an unbelievable trauma for anybody connected with such a child.

Another example is one due to a chromosomial defect, Down's syndrome. Mongolism is one example of this.

Women over the age of 38 have a high risk of having Down's syndrome. Usually these families are identified after the birth of the first defective child.

Prenatal diagnosis is carried out in the same way. Chromosomes rather than enzymes are defective in these

(p. 91)

cases.

Q. Dr. Punnett, with respect to your description of tay-sachs, can you explain in great detail how couples who would be carriers of this disease could be identified?

A. This disease—let me backtrack. The gene that causes this disease happens to be present in a higher concentration of persons of the Jewish faith from Eastern Europe.

There is voluntary screening of this. Couples that might be concerned, they can go to a clinic and have their blood analyzed. Individuals who are carriers of the disease would have one normal gene and one abnormal gene.

Biochemically we can separate three classes of people: people with two normal genes; people with one, and people with no normal genes for that particular enzyme.

It is possible to recognize individuals who are carriers, simply by screening that population before they have a defective child.

Q. What would the extent of the risks be in a couple having a defective child, as a result of the pregnancy?

A. If both are carriers, the pregnancy carries a 25 percent chance of this child having a disorder.

Q. What are the options?

A. The couple can elect to have no further children. Some families went on and rejected the advice of having no further children, and decided to have children regardless of

(p. 92)

the consequences to the child.

Other families monitored the pregnancy, and had the defective child aborted.

Some families will also accept artificial insemination. In the case of artificial insemination, where the sperm donor does not have defective genes, the mother will have a chance of having normal children.

Q. Doctor Punnett, does part of your experience include the counseling of such couples?

A. That's correct.

Q. What do you tell these couples in a counseling session?

A. We explain to them scientifically on whatever level they are familiar with, the diseases and how it affects their child; how it could affect the child if they have one.

We would explain to them how it is inherited; why it is that two perfectly normal people can have an abnormal child.

Then we explain each of the options open to them. If the wife is not pregnant, we tell them whatever they decide to do we are always there to give them help and advice and keep them up with new developments.

If the woman is pregnant and wants to go through the term, we will help them through the termination with testing, or whatever it is they desire.

Q. Where the couple decides on an abortion, what would the

(p. 93)

time table be?

A. As we pointed out this morning, the same conditions hold for abortion.

It is not feasible to get embryonic enzymes under 16 weeks, because the uterus is not large enough at that time.

Q. Are you referring to the actual word, gestation?

A. Sixteen-week gestation, or 18 weeks after the last menstrual period.

Also, the cells do not grow as easily as the cells obtained from the menstrual period. The embryonic fluid contains a variety of cells, only a small fraction of which actually grow.

We take the cells from the embryo and we put them in a flask, then put them in an incubator, and hope they grow. If they grow, it will take two to six weeks for the test to be concluded. The way the cells grow there are a number of variables that enter.

The cells could be tested for the enzyme, for the chromosomes, or whatever it is we are diagnosing. It would then be communicated to the family; the family would discuss it and, if necessary, we make the arrangements for the termination of the pregnancy.

Q. What period of gestation would be the earliest?

A. With luck, one would have the results on the chromosome

(p. 94)

analysis by the time the tap is done. It might be four weeks before one would have sufficient evidence.

JUDGE ADAMS: If you added the two weeks and four weeks that you mentioned to the 16 weeks you previously mentioned—you indicated the time for testing was not ripe until the 16-week period—you are saying the cycle of gestation is 18 to 20 weeks?

THE WITNESS: Yes, sir.

JUDGE ADAMS: And the menstrual period another two weeks?

THE WITNESS: Yes. I know that is nerve-wracking for the person growing the cells and for the family.

Occasionally, the cells do not grow and we don't know this for a week or ten days. The obstetrician would go back and do a second embryotic tap, and we hope the cells would then grow.

BY MS. WALLIS:

Q. Dr. Punnett, does Saint Christopher's Hospital perform abortions at all?

A. No. We have no maternity service in the hospital whatever. We see patients referred to us by their own obstetrician, and patients that come to us because of their children diagnosed at the hospital.

Q. In these cases you would be seen by the family who elected abortion and diagnostic procedure, where would it be?

(p. 95)

A. It might be at any one of the number of different hospitals, depending on the patient's own obstetrician.

It might also be a patient who has come to us, whose obstetrician is not skilled in doing taps. We might refer that patient to Episcopal Hospital and Temple Hospital.

Q. Through your work you become acquainted with the policies in various hospitals in the City of Philadelphia, with respect to abortion under these circumstances?

A. That's correct.

Q. Now, we have heard testimony earlier making a cut-off point of 20 weeks with respect to abortion.

Is it your experience that that cut-off period applies to genetic counseling services?

A. It is my understanding that once a study has been initiated at 16 weeks—it is my experience that the genetic counseling services will see the family through to the logical conclusion, if that is concluded within a reasonable time span.

I can't say with any more certainty than that. I don't know about any other institutions; I only know about my own patients. You can't keep a family waiting 20 weeks, and then tell them, "Sorry, we don't know."

Q. Have you had experience with Philadelphia hospitals in performing abortions in situations where you have been personally involved in the situation after 20-week gestation?

A. I know of one where I have been involved.

(p. 96)

Q. How would an absolute cut-off point of 20 weeks affect genetic counseling?

A. It would be very, very difficult. One cannot guarantee a family that we will have a result by a magic date.

Sometimes this takes six weeks to get an answer. One cannot do genetic counseling if you cannot follow it to a logical conclusion.

A family will seek other means if at the end of the 20 weeks we still don't have the answer. They may terminate the pregnancy in what would have been a normal baby; or they may carry it through with this awful agony hanging over their heads.

It's a small number of families, but the personal agony to them is awful. If you have seen a child die of

tay-sachs disease, it is not something you wish on any couple, particularly the other children in the family.

(p. 97)

Cross-Examination

BY MR. MANSMANN:

Q. Dr. Punnett, is that the correct pronunciation?

A. Yes.

Q. You have described what I understand is an extremely dramatic and horrendous burden on any family to undergo. You described particularly the Tay-Sachs, which is extremely difficult for the parents and for the child infected with this particular disease. You have said that science has been able to pre-determine who is going to be a carrier, a potential carrier, of this particular disease; is that right?

A. We are able to determine who is a carrier, that is correct.

Q. Who is a carrier?

A. Yes.

Q. And you gave the percentage of 25 percent if both members of the marriage are carriers?

A. That is correct.

Q. What if just one is a carrier?

A. Then there is no risk to the child.

Q. Do you have any idea of the number that is involved, percentagewise, who would be carriers and of the potential of producing such a child?

A. Approximately one in every 15 individuals who is a Jew from Eastern Europe is a carrier of that disorder. This means that the probability of two such

(p. 98)

people marrying is 115 times 115. At any rate, one in several hundred matings would produce an affected child. That is in that particular limited population, Eastern European Jews. The disease is seen in every population in the world, but it is about 100 times rarer. We have seen it in non-Jewish families, black families, Amish families.

Nobody would suggest screening the whole population because it is too rare.

Q. Now we are trying to get an idea of the area that you service, the number of couples you have seen.

A. We do a very small number of screenings because there is a major Tay-Sachs program in the City which is run out of Jefferson Hospital. We don't do general screening. We only do family studies when a family comes to us with an affected child.

Q. Do you have any information as to the approximate number that would go to the screening, is what I am asking?

A. Well, the aim is every Jewish family in this area.

Q. Would go through the screening?

A. To go through the screening. Every family whose parents come from Eastern Europe is at risk.

Q. Do you know how many are found to be—

A. Of that 115 times 115, that is based on the statistics of screening in the number of cities in the United States and Canada that one out of every 15 just from Europe is a carrier.

(p. 99)

Q. Do you know approximately how many, say, in the Philadelphia area, for example, that you would be

familiar with, the number who have this potential problem?

A. I don't know what the Jewish population of the Philadelphia area is; I am sorry.

Q. You do not know what the potential number or probable number would be? If you don't, say so.

A. No, I don't know what the Jewish population of Philadelphia is.

Q. You have recited to us a history of one family who you counseled who decided to have the pregnancy terminated; is that right?—after 20 weeks?

A. No. Actually it was a different genetic disease which I mentioned that I know was terminated after 20 weeks.

There are in that booklet from the New England journal a listing of several hundred diseases. I would say about 60 of them are amenable to prenatal disease. Each one is rarer, but once a family is identified because they had a child they will come back for genetic counseling and frequently for prenatal diagnosis, but not always.

Q. So that you know of one particular instance of your own knowledge?

A. Yes, in which the testing for the particular genetic disease took so long it was after 20 weeks when the fetus was aborted.

(p. 100)

Q. Was this particular abortion carried out?
A. Yes.
Q. In a hospital, I assume.
A. Yes.
Q. In the Philadelphia area?
A. Yes.

Q. Do you know of any other instances where there was an abortion desired and not able to be carried out?

A. I can't speak about other people's experiences confidentially. I don't know.

Q. You don't know?

A. No.

BY JUDGE ADAMS:

Q. Do I take by that answer that what you have been telling us is based on your own personal observations, there may have been a prior incidence of abortions after 20-week periods which are beyond your personal knowledge?

A. That is correct.

Q. But they may exist?

A. They may exist, and I am sure all over the United States they do because genetic counsel service is available in every state.

BY MR. MANSMANN:

Q. But you do not know that of your own knowledge? It is based on your reading or whatever?

(p. 101)

A. It is based on my conversations with other geneticists all over the world, yes.

Q. This one instance that you are talking about, do you know the approximate gestation age of the fetus at the time of the abortion?

A. I believe it to be about 22 weeks.

Q. About 22 weeks was the gestation?

A. Yes.

Q. This abortion was completed and performed even though there had been a policy in the hospital against that?

A. I don't know what the particular hospital's policy was.

Q. That was because of the hospital's policy? We have been talking about 20 weeks as being the hospital's policy.

A. Oh, no. The statement was made that Jefferson's policy was 20 weeks. I know most hospitals and most physicians prefer that. Nobody likes to do a late abortion.

In this case having started the study there was really no alternative but to carry it through.

Q. Of course, you are aware that the procedure that you are describing, the amniocentesis is a fairly new procedure; is that right, as far as diagnostic purposes?

A. It has been used to diagnose Rh papers for quite a while; but that does not involve abortion unless it is a spontaneous abortion. But for genetic diagnosis I would say about five or six years.

(p. 102)

Q. You know from your studies that there are reported cases where the diagnosis was improper; is that right?

A. I know of three cases in which the results did not confirm the amniocentesis. These go back about four, five years.

Q. Nothing more recent than that?

A. No, I do not know of any areas of diagnosis in recent years. Every child that is aborted and every child

that is carried to term after amniocentesis begins the tests are carried out on the living child at the end of the gestation period.

Q. Is this out of the experimental stage, the diagnosis?

A. Yes. There are sources of errors inherent in the particular system.

If one had twins and didn't know it and you did a tap you would only get one twin.

Q. Or perhaps the fluid may have not been from the—

A. One always worries when it is a female child that one might have gotten somehow maternal cells.

Q. You are able to spot that error?

A. I would hope so. We have never had that experience, and I don't know of anyone that really has.

The errors have not always been made in favor of abortion. In one case it was a child that was allowed to come to term who did have a very serious disease. So errors

(p. 103)

go both ways.

Q. I would assume so, that they had made the diagnosis that were was no genetic effect.

A. That is correct.

Q. And the child was carried to term and did have a genetic defect?

A. But the particular procedure that was used is no longer used. A much more refined one for that one is currently used.

Q. It is your testimony that this is accurate now?

A. For every genetic disease that I know for which it is being used it is accurate.

Q. There are other genetic diseases which you have not mentioned which are in that exhibit, you don't have the problem—or do you have the problem with the late diagnostic—

A. Any prenatal diagnosis is going to be in that same time bind.

Q. So that you are talking about not only Tay-Sachs?

A. I am talking about every disease. Anything which requires a cell culture you have that time lag. Any test that you can do on the embryonic fluid then there is no time lag.

Q. So that it has to be after the 16th week?

A. Or generally, yes.

Q. Generally?

A. Yes.

Q. This would be true of any genetic condition in addition

(p. 104)

to Tay-Sachs?

A. Yes.

Q. But you would have a quicker decision in non-cell growing type of diagnosis?

A. It happens to be the one you picked on, which would be open spinabifida.

As common as prenatal diagnosis may be now I am sure that in the next five years many many more of those diseases will prove amenable to prenatal diagnosis, some are common in the Caucasian population. Cystic fibrosis is not now diagnosable.

Q. There is some progress made in these other genetic defects of children born with genetic defects?

A. Obviously if the child is salvageable and nobody is going to be concerned about not allowing that child to come to term.

Q. If a child is salvageable there is no problem, in your opinion anyway, about allowing the child to come to term?

A. This again is a family decision. It is not my decision to impose on the family.

MR. MANSMANN: I have no further questions.

BY MS. LEADBETTER:

Q. This is the booklet that you brought with you?

A. Yes.

Q. Mark it as Plaintiff's Exhibit 7.

(p. 105)

(Exhibit P-7 marked for identification.)

Q. (Continuing) Drawing your attention to Page 3, this indicates, does it not, that Nadler and Gerbey had no maternal or prenatal complications in the series of 150 pregnancies, amniocentesis having been done at 13 to 18 weeks gestation for diagnostic reasons; is that correct?

A. Yes.

Q. So some doctors who are working in this field are doing amniocentesis as early as 13 weeks?

A. This paper is based on some early studies. The general recommendation now is to do it at 16 weeks. Most taps done at 13 weeks do not yield enough cells to grow, and has to be repeated. This is a 1970 paper. That is correct.

Q. It could be tried as early as 13 weeks?

A. Yes, but to no avail and has to be repeated, which is an added trauma for the pregnant mother.

MS. LEADBETTER: No other questions.

JUDGE ADAMS: Does anyone have any other questions of this witness?

MR. MANSMANN: Your Honor, I would change my motion to strike and perhaps we can do this before the witness leaves in case there are any other questions.

MS. WALLIS: May I speak to that motion?

JUDGE ADAMS: We are going to deny the motion to strike at this time. It is always within the ability of the

(p. 106)

Court to strike the testimony as it reviews the findings of fact and conclusions of law. But as of this moment it will not strike with prejudice.

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TESTIMONY OF THOMAS WILLIAM HILGERS, M.D., TAKEN JANUARY 15, 1975

* * * *

(p. 237)

BY MR. MANSMANN:

Q. Now, could you tell me, Doctor, what the immediate complications are generally of a suction and/or D&C abortion? The immediate ones.

A. There are primarily three complications that are significant: The first one being infection; the second one being hemorrhage; and the third one being perforation of the uterus.

Q. O.K. Now, why is there danger from this type of abortion procedure?

A. Well, the abortion process is done or the technique of abortion is done in an area which, from a medical standpoint, is not a clean area.

Q. Now, when you are talking about it not in a clean area, are you talking about the physical facility or the part of the body?

A. No, that's what I mean to clarify. The facilities are clean and sterile in terms of bacteria and organisms that can cause infection, but there is no technical way, even with the use of various kinds of chemicals, to destroy bacteria. There is no way that we can make the vagina or the cervix in that area sterile. It is just a technical

(p. 238)

impossibility.

So that any operative procedure done in this area is liable to infection. The fact that it is a pregnant uterus that we are dealing with does add to the fact that infection is a likelihood. The pregnant uterus is very rich in its vascular supply. It is a sort of, what we would call, a good culture medium. It has all the component's necessary for the growth of bacteria.

Q. And so this is the reason why infection could be prevalent in this particular type of procedure?

A. That's the underlying reasons, yes, and infection occurs from between 5 and 10 percent of women who have abortions.

Q. Now, you are saying that 5 to 10 percent of women who undergo a suction or D&C abortion would stand the chance of having an infection; is that right?

A. That's right.

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(p. 239)

Q. And the next complication that you had mentioned is the hemorrhaging.

Could you explain to me and to the Court the reason that a complication as a result of an abortion could result in a complication in the nature of hemorrhaging?

A. Well, again we are dealing with an organ which has a very rich blood supply to it. Much more so than the non-pregnant uterus. The pregnant uterus, because of its contents, necessitates a very rich blood supply so that in its termina-

(p. 240)

tion, its evacuation, there are blood vessels which are literally torn through in the midst of the operation, and there is a certain percentage of women where this bleeding is not easily controlled and the bleeding will be of significance, more so than there would be anticipated expected bleeding at the time of the operation, but in some woman it is anticipated bleeding, and much more than anticipated. It would then become significant.

Q. O.K. When it becomes significant, is that called a major hemorrhage?

A. Yes, that's one way of referring to it.

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(p. 243)

Q. And you have also talked about perforation and you are talking about perforation of the uterus, I assume?

A. That's right.

Q. And I believe the Court has an understanding as to the method that is utilized in this procedure, and is it the introduction of the instrument that causes or presents the potential risk of perforation of the uterus?

A. That's right. It is not in the process of dilating the cervix or the mouth of the womb in which this occurs, but it is in the curettage aspect or the scraping of the womb by and large that this occurs either with the suction apparatus or the scraping curettage, the two types, and the perforating of the uterus occurs because this is essentially a blind procedure, and the physician is not doing the procedure under direct vision. He can't see, for instance, the top of the uterus or the womb when he is doing the operation, and at times the instrument will perforate through and enter the abdominal cavity.

Q. And what is the consequence of this type of perforation?

A. Well, it depends on where the perforation occurred and to what kind of damage resulted. There are certainly a large number of women who can have perforated uteruses and nothing happens to them. They are only observed for 2½ hours and the perforation heals without any consequences, but more and more we are seeing reports in the medical literature,

(p. 244)

particularly now in the United States, where the blood supply, for instance, to the uterus, the major arterial blood supply to the uterine artery is perforated and lacerated, resulting, of course, in major internal hemorrhage or where the bowel is perforated as well.

During the process of this perforation of the uterus, it can result in infection and overwhelming abscesses, peritonitis, and so forth.

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(p. 249)

Q. And, Doctor, are they the immediate and perhaps because there is the three-week intermedial complication, that could reasonably be anticipated from an abortion procedure?

A. Yes, I think so.

I might throw out one other that is perhaps more of an—in terms of a minor problem, and that deals with

(p. 250)

retained placental products or product of conception, some people like to refer to them. This is tissue that is left in the uterus following the abortion. By and large this is not much of a problem with the D&C type of abortion because the woman is scraped clean, but it is a little bit more of a problem with the suction type of abortions.

Q. What is the effect on the woman if there is part of the placenta remaining?

A. Well, it does a couple of things. First of all, that tissue left behind is a good culture medium, as I referred to before, in the sense that it can introduce bacteria and be a stimulus for infection or site for infection, and the other problem is that it doesn't allow the muscle of the uterus to work effectively and so hemorrhage is more common when this happens, but as a result of this, people doing these procedures, by and large, follow up this suction procedure with a sharp curettage of the womb to prevent these problems.

Q. And that would generally prevent the problem if there is a curettage after the suction is applied?

A. That's right, it prevents the problem of having placental or tissue left behind. It doesn't prevent the other problems that I have referred to.

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(p. 263)

Q. Doctor, we also had described to us yesterday the saline

(p. 264)

and prostaglandin methods of abortion.

Can you tell the Court, briefly, what the medical complications are from a saline-infused abortion?

A. The same kind of complications medically are found in saline abortions as any other abortion, mainly infection and hemorrhaging, primarily.

With a saline abortion, because it is more "normal," it requires going through a labor process of several hours, there is a fairly high incidence in which there is retained placenta material and retained tissue.

Q. How is that removed, the placenta, after abortion?

A. It requires a curettage, or scraping of the womb to remove the tissue.

Q. That requires the undergoing of a D & C?

A. Yes—not the "D," which is the dilation, that process occurred; but only the scraping of the womb.

Q. These complications, would they appear with the same frequency, other than the retained placenta? Would they occur with the frequency which you previously described with the induced abortion by C section and D & C?

A. They would be a little more common than they would be for the first-trimester abortion.

Q. Would it be statistically higher?

A. From a clinical standpoint a little bit higher.

Q. The retained placenta, do you know how often that would

(p. 265)

occur in a saline infusion?

A. 20 or 30 percent would be a ballpark figure. with the use of saline or salt.

Q. Are they complications that the physician would expect in a saline-infusion abortion?

A. These would be anticipated. There is one I didn't refer to that I should mention.

When a woman has a salt solution that goes into her uterus, there is reaction that goes often into her system. This occurs in a woman that has a saline-immuno infusion. This one is a reaction that affects the blood's ability to clot.

In many women that would be a minor situation, either to her or her physician. By chemical tests, we can tell this is what happens.

In rare occasions the disruption in her blood-clotting mechanism is so severe that she will have a major bleeding, much in the same way as a hemophiliac would have.

Q. Would this be in a small percentage of women, Doctor?

A. The problems of the blood occur in almost all women; but in any major degree, it's a small percentage of women. It's small enough that we couldn't put a percentage figure on it.

However, this is a significant figure because of the material deaths that have occurred.

Q. This would be reflected in mortality rates for saline

(p. 266)

abortion?

A. This is significantly higher for first-trimester abortion.

Q. Do the same complications that you previously described as long-term, or latent complications—would the physician expect to find them in a saline-infused abortion?

A. Such problems as miscarriage and other kinds of pathological problems, are not generally associated with the salt-immuno procedure.

Q. As far as the long-term complications that you just listed, you would not find that complication as a result of a saline abortion?

A. Yes. With the exclusion of trans-placenta, those are the same as the other abortions which problems are unique with the first-trimester abortion, the D & C and D & E. Many of them are associated with the problems of widening, opening the mouth of the womb.

Q. Is that the reason they would not be anticipated, because of a saline abortion?

A. That's right.

Q. In the saline abortion, there is a more natural process involved in that abortion?

A. Natural from this standpoint: it involves the woman going through labor. It is unnatural from a lot of other standpoints. The contractions that occur in labor pains are much stronger, if you measure them with certain instruments

(p. 267)

we use for that.

You get a tear in the mouth of the womb following a salting-out procedure, a complication I will not refer to, but there have been a number of cases on that.

Q. Would that result in scarring, Doctor?

A. It may, but not necessarily in the same problems.

Q. Doctor, in the prostaglandin abortion, would the morbidity rates be about the same as the abortion infused by saline?

A. I think from my own investigation, the morbidity rates are about the same. We still don't have enough information with regard to prostaglandin abortion to know it is higher, lower or about the same. The indications are that they are comparable.

Research in prostaglandin as to their use has only been going on for about four years. It will take more time to throw out a line on it.

Q. Would the prostaglandin procedure—would that be safer from a mortality point of view than the saline?

A. I can't imagine it would be safer. But, frankly, we don't have good, solid information yet because it is quite new.

I can't imagine it would be safer than the salting-out procedure.

Q. Now, Doctor, there is one method left, the hysterotomy method.

(p. 268)

It has previously been described as a miniature C-section. Is that accurate?

A. From a surgical standpoint, that is reasonably accurate.

Q. What complications arise from a hysterotomy?

A. The hysterotomy abortion carries with it the highest mortality rate for all procedures of abortion.

In New York there was 350 per 100,000, and that has been reduced to 200 per 100,000.

In the hysterotomy you run into the same problems as any major abdominal operation. The overall incidence of complication runs 35-45 percent, which includes infection and hemorrhage, primarily. There are other nuances, but they are the primary ones involved.

Q. Do you know what the percentage the physician could expect as far as hemorrhage and infection in hysterotomy?

A. 35 to 40 percent.

Q. Would the performance of a hysterotomy normally require having subsequent children by C-section?

A. As a general rule a subsequent child would have to be delivered by C-section. As a general rule that would be accepted medical practice.

Q. What is your medical opinion where all of these procedures should be performed?

A. I think they should be performed in the hospital setting with the proper kind of back-up, blood teams and other kinds

(p. 269)

of specialities; a cardio-pulmonary resuscitation team would be available, and the whole gamut of expert care.

* * * *

(p. 285)

Q. Doctor, you testified that one of the leading causes of motor and mental retardation was premature birth to the extent it occurred.

A. That's right.

Q. Can you tell me whether or not the possibility of such mental and motor retardation would be apt to apply to a fetus born and maintained in life, delivered, say, between 20 and 30 weeks. Would there be a risk of this problem?

A. There is a risk of this problem with any infant born prematurely.

Q. Can you relate the risk which would occur or which would be endured by a fetus of less than 1000 grams, say, to a fetus of around 2500 grams or slightly less?

A. Oh, the smaller the infant, of course, or the more premature the infant, the greater the chance that this is going to occur. In fact, that's where the modern thrust or the thrust of modern obstetrics really is, in the prevention of premature birth, as much as we possibly can.

Q. Let me ask you this. If we had an infant delivered at, say, 600 grams, and we were able to maintain life, can you give the Court an estimate of the possibility of mental

(p. 286)

or motor retardation of significant symptoms?

A. Well, it depends on what you mean by "significant."

Q. I will withdraw that. You define it however you like, Doctor.

A. Well, that is still a good question because I am not sure that I can give you a good standard medical definition of what the significance is from a motor retardation or a mental retardation standpoint.

I can tell you that for an infant delivered below 1000 grams, and I must qualify this to a certain extent because

I am recalling on my memory, but, as I recall, the incidence of mental and motor retardation runs in the range of about 15 to 17 percent.

Now, I must say that there are—

Q. I am sorry, I didn't hear the percentage.

A. 15 to 17 percent.

Q. Thank you.

A. But I must quickly add to that that there are recent publications now coming where these high risk infants are receiving a particular kind of intensive care and they have been followed up now to the degree where these kinds of problems are being either prevented completely or being markedly decreased in terms of their intensity.

Q. You would hope to reduce the risk as time goes on, I assume?

(p. 287)

A. Well, there are two ways of approaching the problem: One, to treat infants, and this is where we have a great deal to go in terms of our medical knowledge.

The other is to keep the infant in its best location, which is in the mother's womb, and I think that is where the general trend of American obstetrics is headed in terms of the world situation, is to try to avoid premature birth if at all possible.

It is very difficult to take a simulator or artifically produce the conditions which are beneficial to the child while in the womb.

Q. In order to understand the context in which you were working with that statistic, the 15 to 17 percent, I just want to ask you a couple of clarifying questions; one of which are we talking about a premature infant of 1000

grams or slightly less handled in a specialized or intensive care situation?

A. Not necessarily, no. We are talking about the general handling of these infants.

Q. In an ordinary as opposed to a non-teaching hospital?

A. That's right.

Q. Then you feel that with neonatology and with specialized equipment, we might be able to improve birth rate?

A. I think that we will be able to improve that, but we will never be able to overcome it, I am sure.

(p. 288)

Q. Secondly, as a matter of context, does the 15 to 17 percent relate to all births at this age or to those surviving for some period of time, and, if so, what period of time?

A. It refers to those who survive and obviously the ones who die, it is not a question of mental or motor retardation.

Q. Yes, you are excluding them from the population?

A. Sure.

Q. And what, if you will, lengths of survival is necessary to determine the probability or the incidence of this mental or motor retardation?

A. Well, that is a difficult question for me to answer since I am not directly involved with either the study or the care of these infants. That is not my field of expertise.

Q. O.K.

Doctor, I want to ask you to give us, if you will, your opinion in gestational age of viability, and I will define the term for you, if I may.

I would like to define for you or for you to use this definition: Viability means capability of a fetus to live outside the mother's womb albeit with artificial aid, and you may assume that the artificial aid is not the intensive aid available only in a teaching hospital for the purpose of the definition I am giving you.

Could you tell us at what gestational age in your opinion, that status; that is, viability, is attained?

(p. 289)

A. Well, first of all, in my opinion, one cannot give a specific gestational age. The concept of viability as you have defined it depends on a number of factors.

Q. You may wish to indicate to the Court, incidentally, your reservation about the usefulness of the definition at all in terms of your own philosophy.

A. Well, I can only say that from a practical medical standpoint the term viability as referred in general to the kind of definition that you have given, the ability for the child to live independent of the mother, but the determination of when a child is or is not viable is one that can never be accurately determined before the child's birth. Some reasonable judgment can be made regarding it.

One has to put together though a number of factors. One has to put together the history, the medical history of the woman; when her last menstrual period is. One has to consider the size of the infant. Most medically accepted concepts talk about 500 grams.

As a matter of fact, there have been recorded incidents of children living on to adulthood at smaller than 500 grams; as low as 370 or 380 grams so that the size, weightwise, of the baby would be quite an important consideration.

Gestational age does fit into sort of the multi-factor approach one has to come to deciding whether

(p. 290)

a child is viable or not, and I think the consideration of what facilities are available in a community also enters in. Certainly the medical center, where there is well qualified or very specialized, if you will, medical care, the concept of viable will have a little bit different meaning than it will have if you are out in a rural area where we have no such facilities, and certainly one thing we do know is that viability is being pushed back and back.

Q. Let me ask you another question along that line. I realize that it makes it difficult to answer, and I will allow you to define the terms any way you like, if you wish, but I again want to use the definition of my ability I gave you; that is, the ability of the fetus to live outside the womb albeit with artificial aid.

I want to ask you, Doctor, if you would give us the factors or the gestational age which would allow you to determine, or at which point you could make a determination that a fetus is viable or that there is sufficient reason to believe that the fetus may be viable exercising your professional skill and care. Can you give us a gestational age or some other factor which would relate to that to permit you to make the determination?

A. Well, I think what I just completed saying was that for me to make any reasonable judgment regarding

viability, and it would not in any way be infallible judgment, for me to make

(p. 291)

any sort of reasonable judgment regarding it, I would have to consider a number of variables.

One is the gestational age. One would be the size of the infant as I would estimate, or guesstimate as we would say in obstetrics, because it is very difficult by abdominal aid, feeling the mother's womb, abdomen, that would require investigating her past medical history; when her last menstrual period was; whether or not that fits in with the size of her uterus, and certainly in terms of whatever medical facility might be around in the area at the time, and whatever kind of medical advances we might be working on at the present time also.

Q. Can you give us, if you will, assuming the medical facility available in a normal hospital, but not a teaching hospital, those indications in terms of weight which you are able to palpate or X-ray and gestational age as you term it from the history given you by the woman, at what point you yourself would reach the professional judgment that the fetus may be viable?

A. I think that if one has a reasonable judgment medically that the woman is four and a half to five months pregnant, both from terms of the size of her uterus, and in terms of her past menstrual history, and if the child's estimated size were over 400 grams, by estimation one could make a reasonable judgment that this baby has now reached that point

(p. 292)

of what we call viability, but I must say that—

Q. That is a might be viable proposition, right?

A. That's right.

Q. Go ahead. You were going to say, "I must say."

A. Well, I must say that the determination of a 400-gram size unborn infant is very difficult.

Q. All right.

Now, Doctor, if you were to attempt, given the determination, the factors as you have outlined; e.g., an infant of something on the order of 400 grams, and I think you said five and a half months pregnancy; that you desired to give that infant the best chance of survival although you were going to remove it from the womb, what procedure would you use?

A. If I were to give that infant the best chance of survival given—

Q. The factors you enumerated. How many months was it?

A. Given removal from the womb?

Q. Yes.

How many months did you indicate?

A. Four and a half to five months.

Q. Four and a half to five months, at 400 grams, approximately slightly more.

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(p. 294)

BY MR. MORRIS:

Q. Doctor, you have now read Section 5-A of what is referred to as the Abortion Control Act in Pennsylvania, and what I want to ask you is under that section if you were to exercise that professional skill, care, and diligence which would preserve the life and the health of the fetus, as well as the life and the health of the mother,

as indicated in that section, with all the other qualifications of that section, what procedure would be used to deliver a four and a half to five month fetus which weighed 400 grams or so?

A. I would think that the use of prostaglandins would probably be the best procedure to use.

Q. And what would be the chances of survival of that fetus if you used that treatment?

A. Well, it depends on another variable. Viability depends not only on some of the factors that I have explained but it also depends on racial differences.

As a matter of fact, black infants have a viability that is much earlier than white infants, for example.

Q. I am asking you to assume then, if you will, a black infant. What would the chances of survival approximately be for that infant?

A. O.K. If the infant is at approximately 20 weeks gestation,

(p. 295)

survival through the neonatal period would be in the range of 20 to 21 percent to make it through the first month of life, and this is based on a study done in New York City of 650,000 live births broken down by gestation age and by weight.

Q. And I take it some 15 to 17 percent of those might have motor retardation or some form of mental problem?

A. I am not advocating that this be done, sir, so I—you know, I hope that that can be understood. I could not be doing this for a number of reasons, one of which—

Q. Why would you not be doing it?

A. Well, one of them, the exact thing that you are talking about, the problems that one has in terms of prematurity, and my role as an obstetrician is to take care as best I possibly can of two individual patients.

If I am going to risk the premature birth of a child, I am doing a great disservice to that child, and I would not perform this procedure as a result of that. I can prevent that problem, that 15 to 17 percent, easily.

Q. The best way, I take it, in terms of your advice, is unless it is an otherwise normal pregnancy, to preserve the life of the child would be to carry it to term?

A. Oh, yes.

Q. Doctor, I notice you selected prostaglandins for this procedure under 5-A rather than hysterotomy, or perhaps it

(p. 296)

would be called a Caesarean section if it would be a live birth. Why?

A. Well, the prostaglandins, I think, are probably safer than a hysterotomy, and as I indicated before, we don't have all clear information yet on prostaglandins, but from what we do have, I would think that they would be quite a bit safer than a hysterotomy.

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(p. 299)

Q. Doctor, our last question related to the 15-to-17 percent which you related when you were discussing motor retardation.

I ask you if you can, using Exhibit 6, clarify that statistic which you gave us?

(Handing P-6 to the witness.)

A. The incidence of mental retardation is 3.5 percent for infants weighing 1500 to 2500 grams; the premature group is 7.4 percent; infants weighing less than 1500 grams, the incidence is 17.7 percent.

That indicates what I was saying, the smaller the child the higher the incidence.

Q. Lastly, as you have used the material for providing the statistic, what in terms of severity do you classify as mental or motor retardation?

A. The data as I just presented it is not broken down in terms of degrees of severity.

We are talking about children who will become cerebral palsies, some children will have gross motor retardation and mental retardation.

As to severity I don't have that broken down and I don't recall from my source of information what that breakdown would be.

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TRIAL TESTIMONY TAKEN JANUARY 16, 1975

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(p. 332)

MRS. MANSMANN: From the deposition of Dr. Gerstley. Since I am not certain we have previously identified it, it was taken November 21, 1974. Present for Dr. Gerstley is Miss Sharon Wallis; for the Commonwealth Mr. Mansmann.

At Page 13:

"Q. Is prostaglandin a fairly new method?

"A. Yes.

"Q. Have you any experiences with that?

"A. Have I used it myself?

"Q. Yes.
"A. No.
"Q. Your hospital?
"A. Yes.
"Q. Do you have any reports back on the success or lack of success?
"A. It is by and large a quite successful method. It is not quite as successful as the saline method in terms of the fact that with a saline usually a single injection will produce the abortion in time, whereas

(p. 333)

prostaglandin you may have to go to repeated injections for it to be successful. Granted those two things, I think one method is just about as successful as the other."

MRS. MANSMANN: Back to the deposition of Dr. Franklin at Page 33:

"Q. What about prostaglandins, have you had any experience with it?
"A. No experience with it.
"Q. Do you have any knowledge of it?
"A. I have done some reading.
"Q. Do they carry the same life threatening—
"A. No. A small volume of prostaglandin can be induced into the uterus. It goes into the cervix. You can put a tube into the cervix and put the prostaglandins in, constrictions ensue and the patient aborts.
"Q. What effect does that have on the fetus?
"A. I don't know. I have no idea as to whether it has any effect on the fetus or not.

"Q. Do you know whether or not the saline does?
"A. Yes, I do. Saline does the fetus in. It kills the fetus."

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(p. 341)

"Q. Do you agree there is one aspect present in the abortion procedure that is not present in the other reproductive surgical procedures and that is the potential life that would be there.
"A. Yes, I agree with that."

MR. MORRIS:

"Q. And do you agree that at some point—and this is probably your own philosophical reasoning—at some point there is an interest in the preservation of that fetus?
"A. Not necessarily. I have thought a lot about this question and I believe that life is extended to a fetus or a baby capable of living, if the baby is neglected

(p. 342)

in some way, that does not live, so that one of the prerequisites for life is that someone wants you to live. It may be that they want you to live enough to start an i.v. or to put you on a breathing machine or ventilator but it simply may be that you can be brought into a household where you are fed and sheltered and clothed but the message is you are not wanted, and I believe there is good documentation of absence of growth in children for emotional reasons, namely, societal rejection, and there is a famous paper from the 30's of a nursery where babies were attempted to be raised in total asepsis, no bacteria at all, and these babies died because they were not handled, not talked to, in fact, neglected. So my own philo-

sophical definition of life necessitates other human beings who want you to live. That is why I regard this thing, again, as a piety. It is not practical. If the State legislature wanted to do something, they should provide stipends to single mothers, they would provide day care centers, they would provide rewards for having babies. What they are providing is punishment for having them or punishment for having the abortion, excuse me. Welfare mothers would not qualify in this case. She would have to find the money in this case."

MRS. MANSMANN: Again reading from Dr. Franklin's deposition at page 18. The discussion was with a saline infusion. The question is:

(p. 343)

"Q. Is this done as an inpatient procedure all the time?

"A. Not constantly. There are some areas where physicians have reported doing it as an outpatient procedure.

"Q. What would your medical opinion be on the advisability of that?

"A. Not taking a great deal of risk to do it as an outpatient procedure. From the psychological, I would view the procedure as far more difficult than the suction abortion and, therefore, require more support of the patient.

"Q. Using one of those procedures, it would be of more psychological harm?

"A. The woman is having 8, 10 hours of contractions similar to labor, and to send her home to an environment you know nothing about seems to me inhumane.

"Q. And is the fetus expelled?

"A. The fetus is expelled and the placenta is usually expelled. Sometimes you have to help that out. Sometimes it is incompletely expelled.

"Q. That is incomplete?

"A. Yes.

"Q. Does that require some surgical—

"A. Yes, to get the remaining placenta out.

(p. 344)

"Q. Is the fetus expelled in what form, that the woman could see the fetus?

"A. Oh, yes. Fetus is expelled either covered by the sac or simply as fetus with the cord attached."

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TESTIMONY OF WILLIAM J. KEENAN, M.D.,
TAKEN JANUARY 17, 1975

(p. 530)

* * * *

BY MR. MANSMANN:

Q. Will you tell the Court, please, Doctor, what the relationship is between the mother and baby while the baby is in-utero?

A. Well, the baby is obviously depending on the mother and father for conception and well-being.

While the baby is in-utero it depends on the mother for oxygenation and nutrition across the placenta; and is dependent upon the mother for temperature control and being warm.

Q. So that the baby would depend on the mother for warmth, nutrition and the supply of oxygen; is that correct?

A. That's right.

Q. Are there any functions for which the baby depends solely on the mother?

A. Well, in the last 20 years there has been considerable research in this area. More people are beginning to touch on the area of the metabolism of the fetuses and nutrition of the babies.

In terms of independent function, most of the things—as an example, thyroid hormones, which is

(p. 531)

necessary for growth—we are all familiar with people that have a malfunctioning thyroid gland—the baby depends on itself for that.

In terms of the baby's insulin, insulin is secreted by the pancreas, which is obviously an independent function of the baby.

The baby's independent functioning is measured by 12 weeks' gestation, so that the baby has evidence that his own functioning is doing the job. Most of that is done in Pittsburgh, by the way.

Q. Thank you. Doctor, can you give us any other examples for which the baby is responsible for himself or herself, and not dependent on the mother?

A. There's a lot of them. For instance, the baby is on circulation, and all the physiologic functions we have obviously are developments and the baby—by eight weeks the heartbeat forms, and we have been able to use advanced technology to detect the baby's heartbeat and circulation in 12 weeks.

Q. Now, during the course of this trial we have heard the process called amniocentesis. Can you tell us what that is, Doctor?

A. Well, that is using a needle to puncture the woman's abdominal wall, which goes through the wall of the uterus and into the amniotic sac, and a sample of that fluid is

(p. 532)

drawn for analysis.

Q. So that the fluid withdrawn is the fluid of the baby?

A. The bulk of the fetal urine is the baby's as well as the amniotic fluid, and the baby excretes it through his kidney.

Q. At what period of gestation is this procedure normally done?

A. We do quite a few amniocentesis. I work in a city.

It depends on the indication. We normally start that at about 20 weeks' gestation. We check throughout the pregnancy.

Q. When would the earliest period of gestation be in which amniocentesis would be generally carried out on the mother?

A. In our hospital, Cincinnati General Hospital, the routine is to do it at 14 weeks.

Q. Would this be the time at which this procedure would be completed for the purpose of detecting a possible Tay-Sachs problem in the child?

A. This is a routine where if the family is suspected of Tay-Sachs disease, the system as it works in our hospital is to schedule amniocentesis for 14 weeks.

Q. Doctor, is there, while the baby is in-utero, a period in which there is a gas exchanged within the fetus?

A. The baby is constantly—there are two organs in the fetus designed for gas exchange; one is the placenta and the

(p. 533)

other is the lungs.

The baby does not use the lungs for respiration in-utero. Beginning at 12 weeks there are various vigorous respiratory movements of the fetus.

The baby circulates blood through the placenta, which is his organ, and it also picks up nutrients.

Q. The exchange is done through the placenta originally; is that correct?

A. Yes.

Q. Is it done through the placenta the whole time that the baby is in utero?

A. Yes.

Q. At that time there is also the development of the lungs?

A. Yes.

Q. Can you tell the Court when the first marked development occurs in the fetus?

A. There are several times that we use to teach medical students. To illustrate, the development is a continuing process.

One of those landmarks is 8 weeks' gestation when the organ development is complete. At that time the baby has all the organs that he ever will have. He has a liver, spine, et cetera.

The organ genesis is complete at 8 weeks.

Q. When is the heartbeat first able to be detected, Doctor?

(p. 534)

A. The heartbeat is formed by 8 weeks, and is probably beating at that time.

In terms of documentation, it is 12 weeks by using ultrasonic techniques which are readily detectable.

Q. In other words, the heartbeat is able to be detected between 10 and 12 weeks of gestation?

A. Yes.

Q. What about the development of the fetus when it reaches 20 weeks' gestation?

A. That would be a premature infant. The skin is thin at that point. A black baby is a black baby; a white baby is a white baby.

The babies in my experience, in terms of the lung development at that time, for a period of the time the baby is able to exchange gas at that time, and there is vigorous respiratory movements in terms of picking up oxygen and getting rid of carbon monoxide.

Some of those babies develop infection and other things and others go home.

One had to change our opinion a little bit as to preconceived notions. We talk about a baby that we see at 20 weeks' gestation, and there is respiration and ventilation at that point.

Q. You are talking about exchanges of gas in the lungs as opposed to through the placenta?

(p. 535)

A. Yes.

Q. Do these 20-week babies survive?

A. Not in our experience, no.

Q. What is the development of the fetus at 26 weeks?

A. At 26 weeks, if you continue along the same line looking at ventilation, the baby does have vigorous respiratory movement, does exchange gas and many of these babies survive to go home.

There may be some sort of change in the baby's pulmonary functions at that time.

Q. As the fetus matured from 20 to 26 weeks, that gives the baby a better chance of survival; is that correct?

A. Yes.

Q. There is an increased ability to exchange gases without dependence on the placenta?

A. Yes. The study of pediatrics is growth and development.

Q. Is there a high mortality rate in the 26-week fetuses?

A. There are. As the gestation plods along the line, there is an increasing mortality as the baby increases in development.

(p. 536)

Q. Could you tell us about a baby who is between 26 and 28 weeks of gestation, what would his chance of survival be?

A. In the nursery that I am, you know, primarily responsible for, which is the Cincinnati General Hospital, which is a hospital by charter in Cincinnati that takes care of the indigent patient, our experience over 1973-1974 with 65 babies in that range that you are talking about.

Q. Between 26 and 28?

A. Yes, is 50%.

Q. What about the rate of survival in a 28 to 30-week baby?

A. Well, it goes up dramatically. In our experience, 60% survival.

In a recent article in a journal called "Pediatrics" in December of 1974, they had a 75% survival in that weight group category.

Q. And in your experience about 60% and you know of studies that indicate a 75% chance of survival in a 28 to 30-week baby?

A. Yes.

Q. Doctor, I am going to read to you from the Pennsylvania Abortion Control Act a definition, and I am quoting, "Viable means the capability of a fetus to live outside the mother's womb albeit with artificial aid."

Could you tell us if you would be familiar with that definition?

A. Yes, I am.

(p. 537)

Q. And is it a standard recognized medical definition of that term, viability?

A. Yes, it is.

Q. In the course of your practice have you had occasion to determine whether or not a fetus is viable?

A. Yes, I have, frequently.

Q. How frequently is "frequently"?

A. Well, probably not daily, but certainly weekly.

Q. And would you describe to the Court the method that you would utilize in determining whether or not a particular fetus is viable?

A. Well, on the basis of practice and what everybody does in their approach is first you obtain a history from the mother, just like we would all have histories obtained if we went into the hospital, and with particular

attention directed towards her menstrual history, menstrual dates, trying to determine what time conception took place by using her menstrual history.

Then in addition to that, every woman would be examined externally, by hand, to try to determine not only to look at the height, how much the uterus has grown in total, but also to try to feel for the baby's—the size of the baby's head and the size of the fetal small parts, or hands or feet.

Q. And this is done by an external examination?

A. Yes.

Q. What is the importance of the menstrual history?

(p. 538)

A. Well, the menstrual cycle either—well, menstruation either ceases or markedly changes after conception and so we can take the change or the cessation of menses to indicate what time conception took place.

Q. And the reason for the examination as to the size of the uterus or the abdomen, what is the purpose—what are you trying to learn from that examination?

A. Well, in general the assumption is that this baby is—the more mature the baby grows, and you are attempting to find out the size of the baby by looking at the size of the uterus and the cavity the baby's in, and to look at the size of the baby, too.

Then you try to put them both together and come up with a reasonable estimate of what gestation is at that point.

Q. When you are doing that, would you rely on your medical judgment?

A. Yes, sir.

Q. Is this routinely done in hospitals?

A. Yes, it is a standard the people use every place. If I went to Green County Hospital, which is a hospital that delivers about 400 babies in Ohio, they do exactly the same thing.

Q. So it would be an ordinary procedure?

A. Yes.

Q. And a readily recognizable procedure in determining whether or not a particular fetus is viable?

(p. 539)

A. Yes.

Q. After you had finished your examination, how do you make your judgment on whether or not the fetus is viable?

A. Well, you put the information together, and using a double standard—not a double standard, that's not a good word.

You are using two standards of measurement of gestation and checking one against the other side. Add the information together and with your previous experience, you've come up with an estimate of gestational age.

Now, there are limitations within that in that if I know that I am not a good examiner, for instance, that I really from my previous experience can't tell whether a baby is one pound or eight pounds, I would put less reliance upon that and often—I know a man that I practice with—an obstetrician relies on a certain nurse to tell him, you know, what size she thinks the baby is because he knows that she is more reliable. She has better hands than he does.

Q. So this is part of the process of your making your reasonable medical judgment; is that right?

A. That's right.

Q. Do you use any external data, too, in forming your opinion as to whether or not this baby is viable?

A. Well, by "external data," the way I would interpret that is to mean in previous experience what babies do and what they don't do at a given gestation so—

(p. 540)

Q. It would be that type of information that you would use?

A. Okay, yes. You know, the obstetricians are up-to-date about what our current experience is with a baby of any given gestation.

Q. Doctor, would you be able to base your decision on gestational age alone?

A. Well, not reasonably. I think that's an unreasonable thing to do, take a single parameter and make a judgment on that. In just about every test we have there are certain fallible points and sources of error so I'd say no.

Q. And the reason for that is what?

A. Well, the mother may not remember her dates or if she remembers them, there may be things that influence those dates. For instance, if she has had cessation of menses but she has also had some emotional problem around that period of time, and they may not be pregnant until later, or sometimes in certain women she may have close to a normal menstrual period once or twice after conception, and so you take in, you know, not only was there menstruation, but you know the character of the menstruation and the character of the mother, the mother's previous menstrual history; if she has had regular

cycles, and you would put more reliability on that than if she has had irregular cycles.

Q. Doctor, would you be able to base your decisions as to whether or not this particular fetus is viable on the baby's

(p. 541)

size or weight as you determined it and approximated from the external examination?

A. No. There are failings of that approach by itself, too, in that one is the failing of the examiner; the fallibility. There is a certain error that you would expect that you are within a half a pound, for instance, in your estimate, or you are within a pound, but, you know, it encompasses one or two weeks or three weeks, maybe.

So there is some error in there and then in terms of the baby's growth, you are estimating size and trying to assess maturity and gestation, and some babies grow faster than normal. Like infants of diabetic mothers, for instance, become abnormally large at a given gestation. So that would temper you; the mother's history of diabetes, and some babies grow slower. A mother with chronic hypertensive disease, which is a common illness in our hospital, the babies may not grow as quickly for a given gestation.

Q. So that you would balance these particular factors?

A. Yes, balance one against the other and then come up with an estimate based on a combination of information and how each piece of information fits in with this individual case.

Q. Okay. Are there some new techniques being experimented with or developed which would aid the physician in determining viability?

A. Yes, there are, and most of these techniques are currently

(p. 542)

pretty much within teaching hospitals and experimentally the error and fallibility and reliability of those techniques are being worked out.

The things that we use are amniocentesis and things to measure, for instance, the number of baby cells within the amniotic fluid, so we take over, say, an ounce, and then count the number of fetus—mature fetal cells within that, and then that increases with gestation.

There are certain things that the baby usually puts out in his urine, which we all have in our urine, which increases in concentration with the size of the baby.

Q. This would be another key for you to use to determine what the maturation and gestation of this particular baby is?

A. Yes, and, you know, another promising technique we are using is sonar or ultrasound where you bounce a sound wave off of the baby and pick it up and then by changing the position of your sonar recorder, you can measure the size, for instance, of the baby's head, and the diameter, and so you're looking at a measure of fetal growth, and that has at least some of the sources of error that we talked about in terms of the baby's growth versus his maturity, but it is a very promising technique, I think.

Q. Would that be able to be utilized alone as the determining factor of viability?

A. No, no, that would be—we would not do—we do ultrasound

(p. 543)

diagnosis, but we wouldn't put reliability on that. That would not be good judgment to put our reliance on that measure, no.

Q. That would be a more accurate way than by hand, I assume?

A. It seems to be. It may prove out that way. We have to get more information really.

Q. And is this the same procedure with the sonography, is that used to measure any other portion of the baby?

A. Yes. Well, I mentioned previously that you can use it to record the movement of the heart, the contraction of the heart, and, you know, it is a very nice tracing. You can use it to measure the baby's—you know, the circumference, diameter of his head, and you can measure his length. You move the probe down the abdomen along the axis of the baby, and you can pick up the length of the baby.

Q. Is that what is known as crown-rump length?

A. Yes, crown and rump, yes.

Q. And that again gives you an aid in determining the maturity or size of the baby; is that right?

A. Yes, right.

Q. Could you use that as the sole factor in determining whether or not a baby is viable?

A. No. Again there are some sources of error in the measurement itself people recognize—people who do ultrasound recognize, and then there are sources of error

just from the growth of the baby. You have an average, but the average has a deviation so

(p. 544)

you wouldn't put all your eggs in one basket again.

Q. So you would use a combination? For example, if you were in a teaching hospital, you would use a combination of all or some of these tests or procedures?

A. That's right.

Q. And if you were in a non-teaching hospital, you would use the physical examination that you have described to us?

A. In a teaching institution we use the history and the size of the baby determined from external examination.

Now, in the problem patient, you know, we suspect the growth, that it may not be normal, and things like that, we would go ahead and use other procedures. We don't use those routinely either and they won't—I doubt if they will come into routine use.

Q. Okay. So that is for the problem child that you are concerned about some growth problem?

A. That's right.

Q. So that even in a teaching hospital you would utilize the procedures that you have indicated to us?

A. That's right.

Q. Doctor, would you be able to or are you able to state with reasonable medical certainty the viability or the same situation will exist in every particular case?

A. No. If the mother has an infection, for instance, that would enter into your judgment whether this baby is viable in a

(p. 545)

mother with an infection, and in a 25-week fetus, I think the chances for that baby are very grim. Whereas, the same baby, say, with a mother who has had good nutrition, she has had good pregnancy history, you have good reliance on your information. All those kinds of things, that a baby would have an even better chance so there are a lot of variables, not with the individual, but in judging the individual case. There are things that you take into your formula for judging that case.

Q. All right, and also, Doctor, are there factors that are inherent in, for example, the sex of the baby?

A. Yes, and I guess not really remarkable, but for a given baby after a given gestation, the sex is really very important to determine in that females survive with a given illness and males have a lesser chance of surviving with a given illness.

So often, say, if I bring a sick baby from the delivery room to the nursery, the nurses look at the baby and see if it's a boy or girl and say, "Oh, well, gee, you know, it's too bad he is not a girl," or something like that, just in terms of survival so, yes, that is important.

For instance, there is another one. Race seems to be important. For a given size the baby who is black has a better chance of survival than a baby who is white. A black female in terms of survival is better off than a white male. Those are the extremes.

Q. Doctor, you have explained to us how you would attempt to

(p. 546)

determine gestational age and could you tell us at what point you would place viability? First of all, let's take 28 weeks.

A. Well, 28 weeks for sure, and we have mentioned those babies with a 50—60%, you know, survival, in a nursery. Now, these are babies who are sick. These are babies who had complications; whose mothers were infected, whose mothers had hypertension, all kinds of other things going on, so this is experienced in the real world. It is not an optimal experience.

We hope by better, for instance, better prenatal care, we will be able to optimize that experience with small babies.

Q. What about 26 weeks?

A. Well, again I indicated that many of those babies survive. By "many," I would judge between 10 and 30%. The mortality is increased, you know, with a 26-week gestation versus 28-week gestation, but there is a maybe chance.

Q. And what about before 26 weeks?

A. Well, I think that's more of a problem and in our experience we have about—you know, it is only possible in any case, you know. Well, not from 26 weeks down, but, say, from 26, 24, or so.

Q. So in that period you would say the baby would not be viable, but maybe viable?

A. Yes, yes.

Q. But from 26 to 28 weeks would it be your opinion, and based on your experience, that the baby would be viable?

(p. 547)

A. Yes.

Q. Doctor, is this—

JUDGE NEWCOMER: That is not what I understood him to say.

JUDGE GREEN: I didn't either.

JUDGE ADAMS: The testimony hasn't been thus far. You gave us percentage figures before.

THE WITNESS: Yes.

JUDGE ADAMS: I have jotted them down. You said from 26 to 28 weeks. Of 65 babies that that you had observed in your hospital, there was a 50% chance of survival.

THE WITNESS: That's right.

JUDGE ADAMS: That seems somewhat inconsistent with the last answer. Maybe I am not—

BY MR. MANSMANN:

Q. Doctor, would you explain to the Court, first of all taking 28 weeks.

JUDGE GREEN: Maybe I misheard the question and answer. Maybe the stenographer could read it back.

THE WITNESS: Maybe I misunderstood the question.

BY MR. MANSMANN:

Q. Maybe if we started over again at 28 weeks. Gestational age 28 weeks.

A. Okay.

Q. Would it be your opinion that the baby would be viable?

(p. 548)

A. Yes.

Q. At 26 weeks would it be your opinion that the baby would be viable?

A. Well, mortality has increased.

JUDGE NEWCOMER: In order that I can understand this, when you say that the baby will be viable, are you suggesting that if it is more than 50%, the baby will be viable? You gave us percentage figures.

BY MR. MANSMANN:

Q. Okay. Doctor, when do you determine, at what percentage point do you determine that, as far as chance of survival is concerned, a baby would be viable?

A. Given the disease rate in this country and in our prenatal society, a 10% survival rate for the very small sick baby is—we would say has the highest survival.

(p. 549)

Q. That is viable?

A. That is viable.

Q. So that from 26 weeks you indicated that there was a 10-to-30 percent chance of survival; is that correct?

A. Yes. So below 28 down to 26, that would be about 10-30 percent.

Q. Based on those percentages, would you say that a 26-week baby would be viable?

A. Yes.

Q. And anything below 26 weeks, would you say that baby would be viable?

A. Not anything below 26—26 to zero.

Q. What about 26 to 20?

A. It may be.

Q. That may be viable?

A. Yes.

Q. You wouldn't say definitely the baby was viable?

A. No.

JUDGE GREEN: Doctor, didn't you use the 26-to-24 weeks before?

THE WITNESS: Yes, sir.

JUDGE GREEN: Are you saying it is the same whether you use 26 or 24 weeks?

THE WITNESS: In our current experience, sir, 26-to-24 week babies come to the nursery and go home from

(p. 550)

the nursery.

JUDGE GREEN: That is the 10-to-30 percent?

THE WITNESS: Yes. Now, if you go down to 26 weeks, we do have babies that come to the nursery and survive for a couple of days. They succumb to infection and pulmonary insufficiency and fail.

We don't have survivors in terms of babies going home. We are very close to that point in terms of our current technology.

JUDGE GREEN: That is, the lowest period in which you have babies going home are 24-to-26 week babies?

THE WITNESS: Yes, sir.

BY MR. MANSMANN:

Q. Now, Doctor, in answer to one of Judge Green's questions, you indicated that technology is expanding or advancing; is that right?

A. Yes.

Q. Could you elaborate what the prospects are?

A. This is very important in discussion with my colleagues in the Cincinnati Perinatal Association and the Society for Pediatric Research. We feel it is urgent that you don't define it so closed.

To define it at 28 weeks, that may have been appropriate five years ago but it's not appropriate today; if you define it at 24 weeks, that may be appropriate today

(p. 551)

but it may not be adequate six months or three years from now.

In all of medicine when you talk about any of the advances of the definition of viability, which may be documented by current experience, it may not be supported by any experience in three months or eight months or 24 months.

It's an expanding concept. There's always flexibility downward in lesser-gestation babies.

JUDGE GREEN: Are you saying that in this area it is only the judgment of the treating physician the only thing that can be relied on?

THE WITNESS: Judgment and experience, yes.

JUDGE GREEN: That is the judgment of the treating physician at that time?

THE WITNESS: Babies, usually, of a thousand grams regularly survive. In a couple of community hospitals in Central Ohio they sent us their small babies, because all of their small babies died before.

Now, they are starting to send their small babies to us and we take care of some of those babies in our own nursery at Cincinnati General Hospital.

I know people in Cleveland, at Western Reserve, where they influence the community hospital's practice. It is not necessarily the individual experience, but sort of a cumulative medical-practice experience.

(p. 552)

JUDGE GREEN: All this knowledge and experience and studies, a doctor who has to make a determination whether or not there may be viability, are you saying that has to be his personal judgment?

THE WITNESS: Yes, sir. In making up the judgment he is familiar with the literature; he knows what goes on in the nursery.

JUDGE NEWCOMER: Are you saying that another physician in reviewing that data would not be able to change that decision or judgment?

THE WITNESS: I think medical judgment assessment is what's available to that physician. I don't think anybody would disagree.

JUDGE NEWCOMER: You do not feel another physician would change that judgment or decision?

THE WITNESS: I don't think so.

JUDGE ADAMS: Let me ask it this way: Supposing the woman is on the table in a teaching hos-

pital and there is a question as to whether the fetus she is carrying is viable, and there are 10 doctors present who have a skill in this field, would there be room for differences among those doctors as to whether the fetus being carried by this woman is or is not viable, and the gestational age of the fetus is somewhere between 20 and 25 weeks?

THE WITNESS: There wouldn't be any substantial

(p. 553)

disagreement.

JUDGE ADAMS: But you could not tell us what the answer would be?

THE WITNESS: I can tell you what the answer would be in our delivery room. The baby would not survive.

JUDGE NEWCOMER: Does survival and viability mean the same thing in that context?

THE WITNESS: In the figures that I have given you this talks about babies coming to the nursery, that were delivered in the room, survival in neonatology period, is the first 28 days after birth, and then they go home. That is accepted in the organization.

JUDGE ADAMS: If we have the same setting that I was hypothesizing a moment ago, and the gestational age is 24 to 26 weeks, and you have this same woman on the operating table, and the physicians and the same data, would there be room for difference of opinion among those physicians?

THE WITNESS: This is getting closer to the number. There would be more discussion and they would come to a reasonable agreement.

Depending upon the current state of practice in our hospital and intensive-care nursery, the judgment would be to deliver the baby. The object would be to safeguard the fetus.

At Green Conty Hospital they probably would

(p. 554)

not do anything special. They would say, "Yes, but we would not be able to insure the survival of that baby."

JUDGE ADAMS: Thank you.

BY MR. MANSMANN:

Q. Doctor, then it's the reasonable medical judgment of that particular physician whether or not the baby would be viable?

A. Yes.

Q. He would take into consideration whether he was in a teaching hospital as opposed to a rural hospital?

A. Right. We have a rural hospital closely linked with us. Their situation would be different than Greene County Hospital.

We have a hospital between hospitals; we have an incubator there, resuscitator and delivery, and they can bring the baby back to our hospital, depending on prior arrangements.

MR. MANSMANN: No further questions.

JUDGE ADAMS: Ms. Leadbetter?

MS. LEADBETTER: No questions, Your Honor.

JUDGE ADAMS: Mr. Morris.

Cross-Examination

BY MR. MORRIS:

Q. Doctor, I wanted to make sure I understood one or two definitions.

(p. 555)

When you say "gestational age," are you talking about gestational age measured from the last menstrual period or conception?

A. Upon a reasonable estimate, it is not one or the other.

Q. There would be a two-week period between the two; is that right, Doctor?

A. Yes. The normal gestation would be 40 weeks.

Q. When you speak of 26 weeks, that would be 24 weeks from conception?

A. The standard approach is L & P.

Q. The other term I wanted to make sure I understood is the term perinatal mortality.

What is perinatal mortality, Doctor?

A. It is the first 28 days after delivery. If the mother comes to the delivery room and the baby is alive at that time, and is delivered still-born, that would be included in perinatal mortality.

Q. In some texts the name neonatal mortality is stated. What is neonatal?

A. Neonatal would be 28 days after delivery.

Q. And perinatal would be when the fetus is in the mother's womb?

A. Yes.

Q. In those terms, what does survival mean?

A. Survival means past the first 28 days.

(p. 556)

Q. You would equate "survival" with the phrase that you have been using, "take the baby home"?

A. Yes.

Q. That would be a fair definition of that?

A. Yes.

Q. Now, Doctor, Judge Adams asked you some questions concerning gestational age, and where you would place viability in terms of gestational age; is that correct?

A. Yes.

Q. Let's assume the same 10 doctors standing around the table and examining the woman; would they reach the same conclusion in regarding gestational age, from their examination?

A. They would be very close in terms of the days.

Q. There is a margin of error in that estimate; is that right?

A. That's right. In making the judgment you take account.

Q. The testimony before was the range is plus or minus two weeks either way; would that be correct?

A. That's right. Given the same information, the doctors would come up with the same estimate.

Q. There would be a range of error, wouldn't there?

A. A range of error in the examination and history, and things like that.

Q. And additionally, in measuring or attempting to ascertain the approximate weight of the fetus, there are variables; is

(p. 557)

that correct?

A. Yes.

Q. Would nutrition be one?

A. Oh, yes; the health of the mother.

Q. What other kinds of variables go into it?

A. The presence or absence of diabetes in the mother. Diabetes is a common disease in the community.

The size of the previous baby in relationship to gestation, we use that as sort of an informal formula.

Q. When people discuss—when doctors discuss in papers the survival of infants or fetuses who have variable gestational ages, they discuss that in terms of periods of survival; is that correct?

A. That's correct.

Q. I might ask you this: are you familiar with Alden's, from the Department of Peditatrics, University of Washington—I am not asking you in detail—I am going to suggest a paper—

A. When was the publication?

Q. July, '72.

Based on a five- year experience, 160 infants with birth weights of less than one thousand grams, they found a mortality rate of 87 percent.

(p. 558)

Q. 161 infants under 1,000 grams they found an 87% survival rate?

A. 87% survival.

Q. Oh, I'm sorry, 1,000.

A. Yes, I think they took from 500 to 1,000, right.

Q. That's correct, yes.

A. And that's—you know, so that generally would include the two groups of babies we are talking about, 26 to 28.

Q. Now, when they went down to a sample—I'm sorry, I'm going to suggest another paper to you of a slightly earlier date, which Potter and Davis did analyze in Chicago's on prenatal mortality. That study ended in 1966 and they found what they determined survival of about 5% on a sample of weights from 400 to 1,000 grams.

Would that be in accordance with the experience?

A. Yes, yes, the experience at that time, and that sort of illustrates the point that we were talking about, the change in experience.

Q. It changes?

A. As the technology improves.

Q. As technology improves. Now, incidentally, those two; the Potter and Davis study and the Alden study were done at what could be described as optimum conditions, were they not?

A. Well, not Potter and Davis, no.

Q. Was that not a teaching hospital?

(p. 559)

A. Yes, well, it is, but they never had innotologists.

Q. In other words, 1966 was too early for that?

A. Yes. Well, they just got one in 1973 so they were a little bit further behind.

Q. So you might improve the first percent statistic today by some amount?

A. That's right.

Q. All right. Incidentally, among the variables which would go into the survival possibility, is the age of the mother one?

A. It is not really well established, but we have now a feeling that, you know, in terms of health, yes, age is important.

Q. Can you give me an idea, and I don't want to push you if you don't feel that you can draw conclusions, but is the date attempting to show anything about the relevance in the age, to the age of the mother, to the survival rate of the fetus at a given weight, and if so, what?

A. Yes. I don't think—no, I'm sorry. I can't really expand on that, but there are some—you know, our experience, you know, there are some young teenage mothers who come in and they have—you know, they had no prenatal care, and those kinds of things, and, yes, that is a problem, so in Cincinnati we pay particular attention to the teenage pregnancy in terms of nutrition, and we have a nutritional supplement program going on in the city which, you know, in Harlem it's been demonstrated to improve all those members we were talking about.

(p. 560)

Q. Okay. Excluding that variable and comparing a well-fed or nutritioned teenager with an equally nutritionally advantaged older woman?

A. Well, that's never really been done, not to my knowledge.

Q. Do you have any feelings as to which way the data will go on that?

A. I really don't. It would be interesting to see, you know, how well nourished the American teenager is as tested by pregnancy.

Q. Yes. Now, Doctor, given a surviving fetus, my question to you is can you give us some idea of what chance that surviving fetus will have of difficulties such as motor or mental retardation at various weight ranges?

A. Yes. The older studies, particularly studies done in Scotland, which were very careful, showed a disappointing, rather dismal neurologic outlook for very low birth weight infants and that's what Dr. Dillian wrote about when she examined that problem.

Q. Have you been able to improve that at all?

A. Yes, quite a bit. There have been three articles just in the last—oh, within a year now speaking of the improving prognosis of very low birth weight. By "very low birth weight," to mean either 1,000 grams or below, or 1500 grams or below. The most recent one was last month in 1974 and they talked about the baby below 1,000 grams—you know, the improving prognosis. I think they had 14—no, they had 197 total babies below 1,000 grams, and I think a 5.3% neurologic abnormality which, you know,

(p. 561)

has just dramatically improved over Dillian's data within Great Britain.

Q. What kind of a facility was that?

A. That's a teaching hospital. That's the College of London. They include babies not only born at their teaching hospital, but babies born outside of their teaching hospital; clinics, small delivery service, et cetera, so—but I think I remember—I don't remember exact figures,

but about half were inborn and half were born outside of the hospital.

Q. Were the ones that were born outside brought over to their facility?

A. Yes.

Q. So that at least shortly after delivery, the ones in that sample had the advantage of teaching hospital equipment?

A. Yes. They didn't say—I don't think they said at what time the transfer was done, but, yes, you would assume it was done fairly quickly.

Q. Now, coming back a moment, Doctor, to the survival rate, I am trying to understand what your definition of viability in terms of period of gestation relates to in terms of the language generally used, which we have agreed in percentage tables.

At what percent do you conclude or what survival percent do you conclude represents viability?

A. Well, I think, you know, opinions are formed, you know, including discussions with my peers and innotologists, and

(p. 562)

discussions with obstetricians, and I spend a lot of time in community hospitals, for instance, and so I am an optimist, and I would say that 10% chance of survival is not too bad, but I think in general, myself with the rest of the medical community, would accept 50%, you know, as a very—as a hard-nosed survival that is very good.

Q. Might there be some who accept a 45% timetable?

A. Yes. Then you would look at the data, from where it was, and which babies, for instance, had problems at delivery or had—you know, difficulty.

So there are other parts of that formula that determine a baby's survival, not just the gestation.

* * * *

(p. 564)

BY MR. MORRIS:

Q. Doctor, can you conceive of other doctors respected, whose opinion might be that viability in the sense used in the statute here could take place as early as 22 weeks?

A. Well, you know, we have discussed it and, you know, seeing the newspaper articles from Florida, or whatever, but, you know, a 20-week gestation baby surviving, and I think within the field

(p. 565)

that data is mistrusted, and it is not a reasonable thing. You know, with our current technology, it doesn't jive.

Q. I meant 22 weeks.

A. No, 22 weeks, no. That doesn't jive either. That's not acceptable data and it has never really been put up for peer review or peer criticism. It's newspaper crap. That's not acceptable.

Q. I am not speaking now of what you define as newspaper material. I am speaking of percentage tables indicating that increasing percentages of babies survive as the gestation period, to the extent you can determine accurate, that increases in age.

A. I think that's true, but my answer was in light of the current information, that the date you gave, the

22-week gestation baby, it's not reasonable that that baby survives. You know, everybody mistrusts that information.

Q. That is your opinion?

A. No, it is not.

Q. But what I am asking you is are there any doctors who would disagree with you on that or is it your testimony that all doctors would agree 100%?

A. Anybody knowledgeable in the field would disagree, and I think—well, I don't know Dr. Mecklenberg, and I don't know who he is, but my guess is that he is not a perienotologist.

Q. No, that is correct. He is an obstetrician and gynecologist, but obstetricians and gynecologists have experience in this field,

(p. 566)

do they not?

A. Experience. I don't think they set any of the standards. I think obstetricians and gynecologists who are leaders and more knowledgeable—you know, this is their field of interest, tend to set a standard, and I think among those people that data would be asked to be reviewed.

Q. All right. Let me ask you this, Doctor.

JUDGE ADAMS: I do have the testimony in question. I don't know whether it is helpful or not. If there is no objection, I will read it just so that there would be no disagreement.

MR. MORRIS: Thank you, sir. It would be helpful.

JUDGE ADAMS: It is at page 82, Dr. Mecklenberg, redirect.

"MR. MORRIS:

"Q. Doctor, as one who perform abortions, I want to read you a sentence and ask you what it means to you. The sentence is: 'Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid.' I want to ask you at what stage of gestation you, as one who has performed abortions, would put that definition."

There was an objection, but then he answered:

"I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact

(p. 567)

that it is constantly changing. My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks. Not in the current edition of Eastman's Obstetrics Book, but in the previous edition, the earliest report of survival was reported as a delivery at 20 weeks gestation. In my own experience, the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal."

Now, do you want to ask a question?

BY MR. MORRIS:

Q. Would you be in agreement with that answer, Doctor?

A. Yes, I think I know one of the reasons why it was withdrawn from Eastman's textbook—you know, the claim for a 20-week survival. There has been more attention paid to, you know, more accurate gestational assessment and, you know, current information, and I think that was withdrawn because it doesn't, you know, really make very much sense currently and would be suspect.

Q. So I take it what he cites was suspect, the data on which he relied?

A. Yes.

Q. Doctor, taking the example posed by Judge Adams again where we have a patient that we are examining, but the fetus has

(p. 568)

not yet been delivered on the table, is there any way that you can tell with certainty whether that particular fetus in that particular mother is or is not, will or will not survive, or is or is not viable?

A. Well, you know, assessing the gestation by the methods that we talked about, coming up with a reasonable estimate of gestation, and then again, you know, part of that formula for assessing viability, current experience both, you know, within and without the community, but mostly within, is the important determinant.

You know, yes, I think people in the field will come up with a reasonable medical judgment that the baby will survive and go home. Be it viable or not, I don't know.

Q. Will they do that based on percentage chances?

A. Oh, yes. That would be part of the formula, yes.

Q. Isn't that what you have done in reaching your conclusion; related gestational age to percentage chance of survival?

A. No, but you are asking me in individual cases and that would have to take in some of the other things that we talked about; infection, you know, how well the mother has done; all those other things. So admittedly it is a soft—it begins to be soft, but that is the way medicine is. That is the practice of medicine. There are a lot of things that—

Q. What do you mean by it begins to be soft? Begins to be questionable?

(p. 569)

A. No. It's hard to define in a textbook exactly how you will do it so it covers all cases. There are a lot of things that come into the judgment there that you have to take into account.

Q. I want you to assume that the patient on the table is nutritionally advantaged and healthy in all respects and that the background is unexceptional.

A. Background of what? Of the mother's health?

Q. That the background of the mother is unexceptional in terms which will be significant to you.

A. Okay.

Q. And what I want to understand is how would, that mother presented in that fashion, the examining doctor or doctors be able to do any more than suggest a possible percentage chance that that fetus might have while it was still in the womb.

A. Yes. Well, I think you would start with the percentage. I would agree with you and then on top of that is the mother bleeding or not bleeding; did she have a

premature baby that survived or did she have a premature that didn't survive.

Q. Let's assume none of those things. Unexceptional.

(p. 570)

BY MR. MORRIS:

Q. Let's assume none of those things are exceptional; that would alter the percentage chance, would it not?

A. Not in finding percentage, but it would alter the percentage chance.

Q. You are looking at a table of percentages and you are making some judgment that a 50 percent or 40 percent or 60 percent we will decide that that particular fetus will survive outside the woman with artificial aid; is that correct?

MRS. MANSMANN: I think the witness said he takes into consideration many factors based on this particular patient. As a result, the question as phrased is not based on the testimony.

MR. MORRIS: Can you answer the question?

A. I was going to answer it. All kinds of other things come into play in that situation.

Q. Even after you ascertained every variable you still are faced with a percentage chance of survival or not survival; is that correct?

A. If you divide by a denominator, it is a percentage.

Q. Wouldn't I be fair in saying that an obstetrician or gynecologist faced with the problem of determining while the fetus is in the womb whether that particular fetus is viable, it is really a quick-chance situation, it's soft; is that correct?

(p. 571)

A. It's soft. Like most other things we do and come up with a reasonable estimate, you do the best you can.

Q. The way we are talking here is not the way the doctors think; the way the doctors think is percentage chance and a lot of things; is that correct?

A. Well, in Cincinnati, I work with experimental psychologists. They are appalled at the way we make decisions. There are so many variables that are poorly defined.

They think it should be yes or no or zero or one hundred. That is the way they do things. They have rats, and they think things out.

We don't do it that way.

Q. In the case we are talking about it's not yes or no; it's a possibility?

A. Not yes or no. In terms of percentage you come up with a reasonable chance and not a reasonable chance.

Q. In areas like that, isn't it true that reasonable men can disagree?

A. I have read that.

Q. Isn't it true in your experience?

MRS. MANSMANN: I will object to that, Your Honor. He will have to clarify that by using "reasonable degree of medical certainty."

My objection is to the question as phrased. It goes to the point of "reasonable men." The question should

(p. 572)

be more properly phrased, "reasonable degree of medical certainty."

JUDGE ADAMS: We will sustain the objection.

Rephrase the question, Mr. Morris.

BY MR. MORRIS:

Q. Doctor, isn't it true that among ten doctors discussing this case, the discussion will present opposing points of view?

A. I don't think so.

Q. You think they will all agree?

A. There will be substantial agreement. I don't have any experience—it just seems to be that is the way things are practiced. They change.

What I expect of a doctor in Green County is not the same as I would expect from a doctor in my hospital, exactly.

Q. Say that again, please.

A. I would expect patient-care to be in Green County Hospital—I think that is a good hospital, with reasonable men, as you mentioned—when I go out there we talk about problems. We don't disagree substantially.

If I give them any new pieces of information they'll say, "That's great. We'll see if we can use it."

Q. Doctor, when you are putting variables together there is disagreement as to what the individual judgments are; is that correct?

(p. 573)

A. There's always room for differences, but I think everybody in conclusion can see the other person's differences. They'll say, "Yes, I will do it this way."

Q. Let's suppose that you have reached a point, in your opinion, where a particular fetus may be viable and

you desire for some reason to give the fetus the best possible chance of survival, consistent with the health of the mother, what would your methods of delivery be, of choice?

A. That is more an obstetrician's decision. He is part of the perinatal team.

They may ask me about a drug. I don't deliver babies. I don't know.

Q. Let's assume the fetus is 1200 to 1300 grams, and you wanted to try to encourage survival, would you use a prostaglandin infusion and C-section?

MR. MANSMANN: I must object to that, Your Honor. The witness stated that this is out of his expertise.

JUDGE ADAMS: Are you able to give an opinion in response to the question?

A. In our team approach I defer that decision to the obstetrician.

BY MR. MORRIS:

Q. Do you have any idea what the decision would be?

MRS. MANSMANN: I object to that question. The question as phrased by Mr. Morris doesn't determine

(p. 574)

whether or not a method is better for the mother with respect to the risk factor. The question as phrased very simply does not consider the factors defined in the Act.

JUDGE ADAMS: Do you press the objection?

MRS. MANSMANN: Yes, I do, Your Honor.

JUDGE ADAMS: The objection is overruled.

MS. LEADBETTER: I have a slightly different objection, Your Honor.

I might ask that the question be read back. The question did not include that this is a situation where a decision for abortion has been reached.

I am not certain that we are clear we are talking about abortion techniques as opposed to delivery techniques.

JUDGE ADAMS: I have a feeling that Mr. Morris is going to rephrase the question.

MR. MORRIS: Yes, Your Honor.

BY MR. MORRIS:

Q. Doctor, am I correct in assuming that the best chance of a surviving fetus is to carry it to term?

A. That is not always true.

Q. Is it true in the normal case?

A. Yes.

Q. Let's assume the normal case; assume that we are going to remove the fetus from the woman at 12-to-13 hundred grams;

(p. 575)

assume we also desire to protect the life of the mother consistent with the fact of the removal of the fetus from the womb; would the obstetrician on your team elect a prostaglandin infusion or a C-section?

A. They use both. That is not my decision.

Q. What do you see most?

A. In my experience they never do the normal case. I guess that answers your question.

Q. Doctor, I am going to read a section from the Act, and ask you if you can help us with this section. If it's not within your area of expertise, please tell us.

This is Section 5a. (Reading)

"Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable; and if the determination is that the fetus is viable, or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence."

MRS. MANSMANN: Your Honor, for a witness who has not seen that before that is pretty hard to swallow. I suggest that he may read it before he answers the question.

JUDGE ADAMS: Give him a copy of that to read.

BY MR. MORRIS:

Q. Read Section 5a, Doctor.

(p. 576)

(Handing document to witness.)

THE WITNESS: Can I have a minute to read this?

JUDGE ADAMS: Surely.

BY MR. MORRIS:

Q. Let me ask you whether you have had a chance to read that, Doctor?

A. Yes. In my area of expertise there are obviously—there are things done by management in the pregnancy that does not influence the health of the baby.

In terms of the delivery selected in this instance, I don't think I am qualified to answer.

MR. MORRIS: That is all, sir.

THE COURT: Any further questions of this witness?

MS. WALLIS: I had a couple of questions, Your Honor.

MR. MANSMANN: I was going to ask some more questions, but I will let Ms. Wallis go ahead.

JUDGE ADAMS: Mr. Mansmann is deferring to you, Ms. Wallis.

Cross-Examination

BY MS. WALLIS:

Q. Doctor, can you tell us what period of gestation you would say the fetus is "presumably capable of meaningful life"?

(p. 577)

A. In those babies I talked about, 50 percent and 75 percent in our experience.

Q. Do those babies almost all do very well and are capable of meaningful life?

A. If you take care of the very small baby, I think they will do very well.

I think that the concern is very much tempered with the information available.

Q. If you add the percentage of severe brain damage to the percentage related to survival, at what point in gestation would you say you could determine that a fetus would be "presumably capable of meaningful life"?

A. Going back to the same babies with neurological disability, some of them are severely affected. There were five out of a hundred that were retarded.

That means that 95 out of a hundred were not. Given that information, I would say that baby falls into that group.

Q. Would you say that a fetus of 28 weeks' gestation would be presumably capable of meaningful life?

A. 26, 28.

MS. WALLIS: I have no further questions.

Redirect Examination

BY MR. MANSMANN:

Q. Doctor, Ms. Wallis talked to you about motor and mental

(p. 578)

deficiencies.

Will you tell the Court what causes those deficiencies in the premature infant?

A. It is prematurity, per se. There are vunerabilities in the methods of delivery. If the mother is sick the baby may have an infection. The baby may have a low APGAR score. A lady in New York devised a scoring system. That goes to how the baby does after delivery.

It seems to be more concerned around the birth of the baby. There is the delivery of oxygen and the concern for early nutrition, and keeping the baby warm. It is the very simple things that mothers know what to do.

I am sort of a substitute mother. The thrust of my specialty is preventive medical care. That is defined by many people. I have the opportunity to supply the baby with the things he needs, so that he continues to grow and develop and do well. The figure cited when they picked out the variables, that seemed to be important in the baby's progress.

Q. That would be the physiological reason for the motor deficiencies of retardation?

A. Yes.

Q. Has any progress been made as far as the prevention or cure of this problem?

A. There is lots of progress in prenatal care as to

(p. 579)

nutrition.

I mentioned the program we have in Cincinnati for better nutrition before the baby is born. These babies are healthy. We pay a great deal of attention to the baby's nutrition, even in the first week of the delivery. There is lots of information coming up concerning nutrition.

The area of oxygenation, that is fraught with technology. There is an awful lot going on. In the five years that I have [been a] perinatologist, there is fantastic technology in oxygenation. It has become so sophisticated in levels of management. In keeping the baby warm, one of the research programs is looking at methods in keeping the babies warm and how they relate to the baby's health. We have made tremendous advances in the last three years.

I think there is going to be lots of changes in this field. I talked about the expanding concept.

* * * *

(p. 582)

TESTIMONY OF ARTURO HERVADA, M.D.,
TAKEN JANUARY 17, 1975

* * * *

BY MR. MANSMANN:

Q. Doctor, we have heard from Dr. Keenin and I believe you were in the courtroom for part of it?

A. Yes.

Q. As to the methods that were utilized generally in ascertaining whether or not a particular fetus is viable.

Because that has been covered already, we are not going to ask you to discuss that in detail, but what I would like you to do is to direct your attention and give us the benefit of your opinion and experience as to the gestational age as to when a particular fetus would, in fact, be viable.

Could you tell us at what gestational period you would—

A. Well, I guess because you are talking about Dr. Keenin's type of facts and figures, I think that is what makes me very uncomfortable is the temporality of all of our statements.

Q. When you say temporality of your statements, what are you talking about?

A. I am talking about, you know, that we are talking about medicine. This is not a complete science. We are continually changing and it is, therefore, a total need of

(p. 583)

people to understand that what I say today, please don't quote me tomorrow because the fantastic progress of medicine is such that, you know, we have witnessed things that we would never have assumed would happen and, therefore, I think that at this moment you have to be careful because I am a biologist and there is a temporality, a desparate necessary temporality in all these statements, and when you are trying to make laws, it makes me very uncomfortable because, as a biologist, what I say today, I may have to swallow tomorrow.

Therefore, on the knowledge of today and on the understanding of this temporality of what I say, I think when we are talking about 28 weeks survival, I am also very uncomfortable. We are obsessed with figures. You are obsessed with statistics. They might be marvelous for an engineer doing houses. I am talking about lives.

You are obsessed with so much percent; what about 5 percent to survive, or do you want to let five children percent die; how many percents.

Do you have a hangup with statistics and it makes me very uncomfortable because statistics and medicine don't blend.

You see we are a very inadequate science. We are an art and you want me to be a computer. I can't.

Therefore, to be talking about 28 weeks, you want an argument about, I think with our knowledge of

(p. 584)

28 weeks and the mother, what is her age, what is her race, what care has she got, what is her nutrition? I have to ask a lot of things.

Q. So that if a law said 28 weeks, without any other type of qualifications, you would be very uncomfortable with that particular law; is that right?

A. Indeed.

Q. And the reason for that is the expanding concept?

A. Sure. The continuous, you know, progress of medicine, and also let me tell you something. The incredible times in the past that we have been wrong. You know, maybe that is unusual for a physician to say that but that is a fact.

Q. So that if a gestational age alone were utilized as a test of viability—

A. How do we measure it? You know, we have—we can put a man on the moon, but we haven't got the foggiest idea how long this lady has been pregnant. You know, we have so far not very accurate—scientifically accurate data and we go on when was your last menstrual period, your size. You know, we can measure in one drop of blood 20 samples of 20 different parameters, but we cannot know by certainty, to my knowledge, how long a lady actually has been pregnant.

Q. And so this is a reason for your feeling uncomfortable with setting 28 weeks definitely at this particular time?

A. Yes.

(p. 585)

Q. Do you agree with Dr. Keenin that the point of viability at the present state of medical art is at 28 weeks?

A. Will you repeat that again?

Q. Do you agree with Dr. Keenin that viability, considering the present state of medical art, is at 28 weeks gestation?

A. 20?

Q. No, I said 28.

A. 28, yes.

Q. At 27?

A. Yes.

Q. And would you expect any disagreement among physicians as to that opinion?

A. I would think so, but I also would like to make very clear, you always seem to find disagreement here. I have the feeling that we doctors disagree on everything so, therefore, when you pose to me ten doctors will agree, I don't know. Maybe I work in a very paranoid place, but the place I work no ten doctors would agree on anything.

Therefore, you know, this is oversimplication. When you get ten doctors to agree with you, I am sure you can get ten doctors to disagree in Philadelphia in a court.

Q. Would you expect ten doctors to disagree with you that viability at the present state of medical art is at 28 weeks?

A. Probably not, but most of them would agree with it, but this is, you know, medicine.

(p. 586)

I am sure if they are well informed, they will agree that the fetus is viable, but the human element, and so on, you know, the enterologist will not disagree; a real specialist in that field, which is what counts, because there are all kinds of doctors. The expert, probably not.

Q. Or a more informed physician would disagree with you?

A. Yes. An obstetrician, a person who works in that field now.

Q. And, Doctor, you have talked about the fact that if you said 28 weeks today, you don't want to be quoted tomorrow on that?

A. No way. No, I don't want to be quoted about anything.

Q. I know. Nobody wants to be quoted about anything.

A. Medically, no. Medically you will have troubles with, for instance, you or with us. You know, it is very interesting that I can give a patient of mine a medication that will have the first wrong side effect and I didn't know it. They will take me to court and they will collect a fortune out of that and I didn't have any idea that it was going to happen and you want me to be quoted? No, sir.

This is an art. You know, I cannot measure by logical standards. If you get me into biology, yes. This is very vulnerable. You know, we teach medical students, but what we teach them today in five years is gone and if they haven't read, they are behind.

(p. 587)

Q. So that you are concerned about setting anything that would be too high at the present time than in the future. Is it your opinion that viability is going to be at a lower gestational age than it is presently in the future?

A. It has to improve only in one way, which is shorter and shorter gestational age. Obviously it cannot

be the other way, and what would be right today—you know, I would be very, very uncomfortable as a biologist because of the temporability of our knowledge.

Q. And so if we said that 28 weeks today, you are concerned at three months from now there will be babies who are definitely viable at 24 weeks; is that your opinion?

A. Yes. Sure.

Q. And is that the reason for your feeling uncomfortable with setting it at 28 weeks, for example?

A. Yes.

Q. And it is because of the expanding concept lowering the point of viability?

A. The internal and, hopefully, continuous improving of medical knowledge. We are doing things, you know.

If you get a doctor that expired 50 years ago, and I will get him back on this earth, and I will take him to our hospital and he would make rounds with us, he would be absolutely lost. He would have no idea of what we are talking about, the language, the medications, the machines.

(p. 588)

For him they would be totally unknown. He would be absolutely as lost as anything and I talk to you only 50 years ago.

Q. Doctor, when you are talking about physicians being not a statistical or medicine not being a statistical science, you do use reasonable medical judgment; is that right?

A. Yes.

Q. And there are certain standards that are prevalent in a medical community; is that correct?

A. Yes.

Q. And if physicians measure up to that particular medical judgment and medical procedure, they would be practicing good medicine in your opinion; is that right?

A. Yes.

Q. And you would expect other physicians who are of the same medical community to agree with you that that was good medical care?

A. I would hope so.

* * * *

(p. 592)

BY MR. MORRIS:

Q. Doctor, let me ask you this: Would you consider the word "viable" in its practical application inaccurate and imprecise?

A. That is the practical indication.

Q. By "practical," when you are attempting to determine if a fetus is viable while still in the mother, would it be an imprecise and inaccurate word?

A. When a fetus is able to survive it is. I think they are two different words.

Q. Can you tell us: while the fetus is in the mother, is it viable?

A. No.

Q. Do you know if obstetricians and gynecologists regard it as viable?

A. With a certain degree of accuracy, but not with the measurement with exactitude. We can't tell you at this moment. You have 14 grams of hemoglobin in your blood. I don't have that experience. This is human error and human art and not published. The blood has

so much to put in that machine. When the blood is put in that machine it is one tenth of a gram. I am not an obstetrician; I am a pediatrician.

MR. MORRIS: No further questions.

JUDGE ADAMS: Ms. Wallis.

(p. 593)

BY MS. WALLIS:

Q. Doctor, questions have been posed to you as to how you would estimate viability based on survival.

How do you understand the word "survival"? In previous testimony we talked about perinatal mortality, neonatal mortality and survival after 28 days. Is that the way you are using the term?

A. I am using it from the moment the child is discharged from the hospital. That baby is in the statistics. In the neonatalogy the mortality is 28 days. That's a survival rate.

There are 10, 12 countries in the world that have babies that survive more than our babies of survival. When you define statistics, we don't mean the whole life of the child, to my knowledge. The other countries are accusing us of infant mortality.

Q. As you used the word a minute ago, survival is 28 days?

A. In that context, yes.

Q. That's in the context of making a determination with respect to viability?

A. Those are the ones we have.

Q. As far as you are concerned viability means the capability of the fetus to survive for more than 28 days after birth, albeit with artificial aid?

A. To survive, if you are talking about natology that is 28 days.

* * * *

(p. 595)

Q. What I am trying to determine is whether the words "to live," as it is used in this definition, is a term literally clear to the doctor, or the one doctor might think "live" means to be alive after birth; to another doctor it might mean being alive immediately following birth; and another doctor thinks it means to be alive in the womb, even though it might not be able to survive more than an instant in the atmosphere of the outside world.

A. Number one, to live I understand outside the womb; number two, it will be difficult to be a productive, normal adult. We have to go day by day.

Q. Would you say all those possibilities exist?

A. To live one day, he may die after one day.

Q. Do I understand that your answer was "yes" to that question?

A. To live outside the uterus.

MS. WALLIS: I have no further questions.

JUDGE ADAMS: Are there any other questions of the physician?

MR. MANSMANN: I have one more question, Your Honor. My wife answered that for me.

Redirect Examination

BY MR. MANSMANN:

Q. Doctor, when you are talking about determining viability, you expect a physician to use his experience, judgment and

(p. 596)

professional competence in arriving at that decision; is that correct?

A. Yes.

Q. If you did that you would expect the other physicians would agree with him?

A. Yes.

MR. MANSMANN: That is all, Your Honor.

JUDGE ADAMS: Thank you very much, Doctor.

We appreciate your testimony.

You may call the next witness, if there is one.

MRS. MANSMANN: For the purposes of the record, Your Honor, I would like to read as admissions statements from the deposition of Dr. Andros, which was held on November 20, 1974; and who is identified as president of the Obstetrical Society of Philadelphia.

I am reading at page 32.

(Reading) "Q. So it is your understanding that viability is the ability of the fetus to live outside the mother's uterus?

"A. Correct.

"Q. Do the words 'with artificial aid' confuse you?

"A. No, they do not confuse me. I believe that this is a trueism, just like in serious adult diseases, such as stroke, so forth.

(p. 597)

"Q. Explain that to me? I don't understand what you are talking about.

"A. It is possible for a patient to have serious —an adult patient or a child to have serious brain damage from injury, say, that it is incompatible with survival, unless artificial means of cardio-pulmonary assistance is given.

"Q. And the area we are talking about, when we are talking about the viability of fetuses, we are talking about artificial aid to keep the fetus or give the fetus a chance to survive; is that right?

"A. That's right."

MR. MORRIS: Continuing on page 34 of the deposition:

(Reading) "Q. And how do you determine whether or not a fetus is viable, generally?

"A. At the moment, there is no good test for that, except by—you cannot—there is no good test or diagnostic aid to tell whether the lungs are capable of expanding and maintaining cardio-pulmonary function.

"Q. Don't you really base that on statistics and your experience as a physician, and on the clinical history you receive from the patient?

"A. And the physical findings of size of the baby, et cetera, et cetera. There is no good test for

(p. 598)

determining.

"Q. There is no absolute test?

"A. Right.

"Q. And the point of viability may differ with each particular fetus?

"A. And the condition of the fetus. An infant of, or a fetus of, let's say, 28 weeks, may conceivably eventually survive on its own, but that is very—to me the lower limits, perhaps.

"Q. Of course, that is always lowering it, too, isn't it, the limit of survival of gestational age?

"A. Lowering?

"Q. Right.

"A. No, I am not entirely convinced it can be lowered to infinity or anything like that.

"Q. I am not, either, and I don't think anybody is.

"A. Because we do not have—we cannot determine—there is no way to make lungs, to a certain degree immature, to expand and stay expanded."

MRS. MANSMANN: Which brings me to the section I was going to read:

(Reading) "Q. But this is a developing area in the medical field; right?

"A. Definitely.

(p. 599)

"Q. And that is the neonatalogist's area; isn't it?

"A. Right, that is correct.

"Q. So if I told you as a physician, assuming I had authority to do so, if I told you as a physician that you could not perform an abortion after the point of viability, you would know what I was talking about, wouldn't you?

"A. I would know what you were talking about in general, but—

"Q. You would have to apply that to each particular case, wouldn't you?

"A. Yes.

"Q. And you would have to use your medical judgment to that?

"A. That is correct."

Mr. Morris got ahead of me on one section here, when he jumped ahead to page 36. Oh, yes.

(Reading) "Q. And we are not asking the point of viability; it may differ with each particular fetus; is that right?

"A. That is correct."

MR. MORRIS: I have to continue.

(Reading) "Q. And perhaps a fetus is viable at 24 weeks, perhaps it is viable at 28 weeks; is that right?

(p. 600)

"A. Perhaps. I do not believe that a fetus is viable at 24 weeks, if it is actually 24 weeks' gestation.

"Q. That is a problem, isn't it, to figure actually what the gestation age is?

"A. That is correct."

MRS. MANSMANN: Then we read the rest of that, Your Honor.

Now I would like to read from Dr. Franklin's deposition, page 39.

(Reading) "Q. Doctor, your lawsuit, of course, has attacked the definition of the word "viability" as it is used in the Act.

"A. Yes.

"Q. And you are familiar with what the Act says?

"A. Correct.

"Q. Could you tell me what your definition of the word viability is?

"A. Viability to me means that the baby has a probable chance, we'll say, ten percent or better, of survival with the equipment and skills of an average hospital in this country.

"Q. So viability to you means, I assume, means the ability of the fetus to survive?

(p. 601)

"A. Right.

"Q. Outside the mother's womb?

"A. Right."

* * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

DEFENDANTS' EXHIBITS W, X, Y and Z

DEFENDANTS' EXHIBIT W

Commonwealth of Pennsylvania County of Philadelphia

I, J. EDWARD LYNCH, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area and I am on the

staffs of Mercy Catholic Medical Center and Jefferson Hospitals. In the course of my practice I have performed surgical procedures. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT X

Commonwealth of Pennsylvania County of Philadelphia

I, EDWARD M. SULLIVAN, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area and I am on the staffs of Mercy Catholic Medical Center and Riddle Memorial Hospitals. In the course of my practice I have performed surgical procedures, but I have not performed any abortions. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequent-

ly have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT Y

Commonwealth of Pennsylvania County of Philadelphia

I, ANDREW A. SULLIVAN, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area. In the course of my practice I have performed surgical procedures, but I have not performed any abortions. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am

familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practtice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT Z

Commonwealth of Pennsylvania County of Philadelphia ss

I, JERRY F. NAPLES, having been first duly sworn according to law hereby depose and say that:

Defendants' Exhibit Z

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology, am currently in private practice in the Bucks County, Pennsylvania area and am on the staffs of Lower Bucks St. Mary's and Temple University Hospitals. In the course of my practice I have performed surgical procedures. A true and correct copy of my *curriculum vitae* is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that Section 2 of the Act uses the word "viable" and that it is defined to mean ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the Act is consistent with the way I use, understand and have understood the word in my practice as physician. Furthermore, in my opinion, "viable", as defined in the statute, comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area, understand this term.

4. During the course of my practice and, as in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, the use of medical statistics and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

[Signature omitted in printing]

Findings and Conclusions of Law

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.,
Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr.,
District attorney of Philadelphia County
and
Helene Wohlgemuth, Secretary
of Welfare of the Commonwealth of Pennsylvania
Defendants

PLAINTIFFS' REQUESTS FOR FINDINGS OF FACT AND CONCLUSIONS OF LAW AND DEFENDANT COMMONWEALTH'S AND DEFENDANT FITZPATRICK'S RESPONSES THERETO

102. Dr. Franklin does not believe it likely that a fetus at 25 weeks' gestation would survive.

Commonwealth: Admitted insofar as it reflects Dr. Franklin's opinion or belief.

Fitzpatrick: Admitted that these may be Dr. Franklin's opinions.

103. In Dr. Franklin's opinion, the chances for survival do not become probable until 28 weeks.

Commonwealth: Admitted insofar as it reflects Dr. Franklin's opinion or belief.

Fitzpatrick: In Dr. Franklin's opinion, the chances for survival do not become probable until 28 weeks.

106. Dr. Franklin believes he can make some judgment with respect to viability but that there is a high probability of error in any such judgment, to such an extent that he would expect a close colleague to disagree with it and would not be surprised by such disagreement.

Commonwealth: Admitted that such is Dr. Franklin's belief, however, it is not accurate or legally relevant.

Fitzpatrick: Admitted that these may be Dr. Franklin's opinions.

130. In Dr. Gerstley's opinion, fetuses do not reach the point of viability at exactly the same time and differ by a variance of approximately plus or minus two weeks in gestational age.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

131. On some eight or ten occasions during Dr. Gerstley's practice, he has been involved in cases where there was a question as to whether the fetus involved was viable.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinion.

134. In Dr. Gerstley's opinion: When physicians make an assessment of viability, they try to determine when the last period was, if it was a normal period, if it was not, when was the last normal period, how does this patient have periods, to try to determine when she actually got pregnant, because physicians are dealing on one hand with weeks amenorrhea and weeks gestation. That can apply to the determination of viability, and then other medical factors such as disease or illness that may have skewed these dates one way or the other may apply, and then physical examination is made to determine the size of the uterus and how it fits in with any known disease that that patient may have or how the size of this uterus then fits in with the weeks amenorrhea, weeks gestation, to determine as best physicians can the size of the fetus, and from those factors, physicians interpolate on a scale the chances of the fetus surviving.

Commonwealth Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

135. In Dr. Gerstley's opinion, the margin of error in determining periods of gestation is about four weeks.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.,
Plaintiff

Obstetrical Society of Philadelphia,
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal,
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania,
Intervenor Defendants

OPINION

Before ADAMS, *Circuit Judge* and *NEWCOMER* and GREEN,

District Judges.

(Filed September 4, 1975

GREEN, *District Judge.*

This action comes before this Court upon a complaint challenging the constitutionality of the recently enacted Pennsylvania abortion statute, titled the "Abortion Control

Act,"[1] Act No. 209 (P.L.)[2]. Plaintiffs contend that the overriding purpose and dominant effect of the statute under attack is to discourage and interfere with certain clearly defined, constitutionally protected rights of the plaintiffs. Thus, they claim the statute should be invalidated in its entirety, despite the presence of a severability clause. Plaintiffs seek declaratory and injunctive relief pursuant to 42 U.S.C. §1983 and jurisdiction is invoked under 28 U.S.C. §1343.

On September 26, 1974, a three-judge court was designated on plaintiffs' application and pursuant to 28 U.S.C. §2281. Oral argument on the plaintiffs' application for a preliminary injunction was heard on October 9, 1974, and a preliminary injunction was entered on October 10, 1974, which enjoined the enforcement of Sections 3(b)(i), 3(b)(ii), 3(e), 5(a), 5(d), 6(b), 6(c) except as it requires a licensed physician to perform an abortion within the Commonwealth of Pennsylvania, 6(d), 6(i) except as it relates to 6(f), 7, and the definitions of "viable" and "informed consent" in Section 2. Also on October 10, 1974, this Court granted leave to the Obstetrical Society of Philadelphia to intervene as a party plaintiff.

On December 4, 1974, the plaintiffs filed a motion seeking a class action determination. Physician plaintiffs contended that the members of the proposed class "included, not only physicians who regularly perform abortions, but also those who may, in the course of their practice, be called upon to counsel their patients with regard to the option of abortion, which necessarily includes vir-

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[1]The Act was enacted over the Governor's veto on September 10, 1974 and took effect on October 10, 1974.

[2]35 P.S. §6601 et seq.

tually all physicians who practice in the Commonwealth of Pennsylvania." Plaintiffs also contended that the members of the proposed sub-class included board-certified obstetrician-gynecologists, who were members of the Obstetrical Society of Philadelphia, and who maintained their medical practice in Pennsylvania. The physician class plaintiffs allege that enforcement of the Abortion Control Act would "abridge their constitutionally protected rights: (1) to practice medicine in a manner consistent with the highest standards of their profession, (2) to be protected from unconstitutional intrusion of the physician-patient relationship in the decision making and treatment of pregnancy, and (3) the rights of their patients to terminate pregnancies under the conditions set forth in the Supreme Court opinions in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed. 2d 147 (1973), and *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201 (1973)." On December 10, 1974 this Court certified the instant action to be a class action.

This matter came before the Court for final hearings on the merits from January 13, 1975 through January 17, 1975 and on March 10, 1975. Thereafter, we granted the motions of the Attorney General of Pennsylvania and of the Commonwealth of Pennsylvania to intervene as parties defendant.

Plaintiff Planned Parenthood Association of Southeastern Pennsylvania, Inc. is a voluntary, non-profit health and social service agency, incorporated by the state of Pennsylvania. Planned Parenthood, which has 200 affiliates in the United States and is a member of Planned Parenthood/World Population, is dedicated to providing contraceptive information and family planning service. Planned Parenthood through its various departments, including its medical staff, provides and desires to continue providing services and/or referral guidance with respect to contraception, sterilization or abortion; maintaining in each of these efforts the goal of freedom of choice concerning family size and birth control methods. Planned Parenthood is completing plans to build and operate an abortion clinic, but at the present time it does not perform abortions at any of its facilities.

Plaintiff Dr. John Franklin is a licensed medical doctor practicing in the state of Pennsylvania, board-certified in obstetrics and gynecology. Dr. Franklin is a member of the staff at Thomas Jefferson University Hospital, the medical director of plaintiff Planned Parenthood Association of Southeastern Pennsylvania, Inc., the medical director of Booth Memorial Hospital of the Salvation Army, and a member of the intervening plaintiff Obstetrical Society of Philadelphia. In his capacity as medical director of Planned Parenthood, he supervises the operation of its clinic which provides family planning services, including birth control, pregnancy testing, pregnancy counselling and referral. In the calendar year 1974, Dr. Franklin performed 21 abortions through November 20th; and in the calendar year 1973, he performed 24 abortions. In 1971 and 1972, Dr. Franklin was the medical director of Philadelphia Family Planning, Inc., where he did approximately 10 to 12 abortion procedures a week for one year.

Plaintiff Concern for Health Options: Information, Care and Education, Inc. (CHOICE) is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania in 1974. CHOICE provides counselling and referral for pregnant women; and over 1,000 women have been seen at eight centers in and around Philadelphia. In

addition to its counselling and referral program, CHOICE performs ongoing evaluation of the services available to pregnant women, especially medical services. CHOICE publishes a "Resource and News Bulletin" which is distributed to its counsellors, all social service agencies which assist women with problem pregnancies, and other interested persons.

Plaintiff Clergy Consultation Service of Northeast Pennsylvania is a voluntary organization of clergy and women, who provide free counselling and referral for pregnant women. Clergy Consultation Service counsellors assist approximately 50 women per month, at three sites located in Scranton, Wilkes-Barre and Hazleton. Most of these counselled women are medically indigent, most are under 21 years of age, and most of them are single.

Intervening plaintiff Obstetrical Society of Philadelphia is a voluntary professional association of board-certified obstetricians and gynecologists; formed more than one hundred years ago to represent and protect the professional interests of members of these medical specialties in the Philadelphia area. The Society has over four hundred members who practice obstetrics and gynecology in the Greater Delaware Valley, including Philadelphia, eastern Pennsylvania, Delaware and southern New Jersey.

Defendant F. Emmett Fitzpatrick, Jr., is the District Attorney of Philadelphia County, and he is sued in his official capacity. In his official capacity defendant Fitzpatrick is responsible for the enforcement in Philadelphia of the laws of the Commonwealth of Pennsylvania, including the Abortion Control Act.

Defendant Frank S. Beal is the Secretary of Welfare of the Commonwealth of Pennsylvania, and he is sued in

his official capacity. In his official capacity defendant Beal is responsible for the conduct of the Commonwealth's Medical Assistance program, including implementing the restrictions imposed upon that program by the Abortion Control Act.

Intervening defendant Robert P. Kane is the Attorney General of the Commonwealth of Pennsylvania, and he is sued in his official capacity. In his official capacity intervening defendant Kane is the legal advisor of the Governor and the chief law officer of the Commonwealth.

For the reasons hereinafter stated, this Court holds that the following challenged sections of the Abortion Control Act and the related criminal sanctions are unconstitutional: the definition of "viable" found in Section 2; the spousal consent requirement found in Section 3(b) (i); the parental consent requirement found in Section 3(b) (ii); the determination of viability requirement found in Section 5(a); the performance of an abortion requirements found in Section 6(b); part of the reporting requirements found in Section 6(d); the prohibition of advertising requirement found in Section 6(f); and finally, the subsidizing of an abortion requirement found in Section 7. And for the reasons hereinafter stated, we hold that the following challenged sections of the Act and the related criminal sanctions are constitutional: the definition of "informed consent" found in Section 2; the informed consent requirement found in Section 3(a); the disposition of dead fetuses requirement found in Section 5(c); the determination of pregnancy requirment found in Section (6a); the facility approval requirement found in Section 6(c); part of the reporting requirements found in Section 6(d); and finally, the Health Department regulation requirements found in Section 8.

I. Justiciability

The threshold question for consideration is the justiciability of the instant litigation. The state challenges plaintiff's standing to contest the validity of the challenged statute in this case which lacks, as a party, a pregnant woman who has been denied an abortion. Initially the state contends that the plaintiff-physicians have no standing to bring this action. Standing, of course, entails

> . . . such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions. *Baker v. Carr,* 369 U.S. 186, at 204, 82 S.Ct. 691, at 703, 7 L.Ed. 2d 663 (1962).

The state defendants appear to have overlooked the Supreme Court's treatment of a physician's standing in *Roe,* wherein the Court stated at 410 U.S. 188, 93 S.Ct. 745:

> We conclude, however, that the physician-appellants, who are Georgia-licensed doctors consulted by pregnant women, also present a justiciable controversy and do have standing despite the fact that the record does not disclose that any one of them has been prosecuted, or threatened with prosecution, for violation of the State's abortion statutes. The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief. [Citations omitted.]

We hold that the plaintiff-physicians in the case, *sub judice,* are not required to risk becoming defendants in criminal prosecutions since they have standing under the rationale of *Roe.*

We have previously determined that the physician plaintiffs may maintain this action on behalf of themselves and "the class of Pennsylvania physicians who perform abortions and/or counsel their female patients with regard to family planning and pregnancy including the option of abortion, and the sub-class of members of the Obstetrical Society of Philadelphia who practice in Pennsylvania." The evidence establishes that the physicians included in the class have patients who are married and desire abortions without spousal consent, patients who are minors and seek abortions without parental consent and patients who are indigent and must rely on Medical Assistance for payment of the costs of abortions[3]. Accordingly, we consider the instant action to be maintained on behalf of the class physicians and their patients in these three categories.

The state also contends that the plaintiff-referral agencies (i.e. Planned Parenthood Association of Southeastern Pennsylvania; Concern for Health Options: Information, Care and Education, Inc.; and Clergy Consultation Service of Northeastern Pennsylvania) have no standing to bring this action. Few would dispute that a referral agency actually threatened with prosecution as a counselor-conspirator or accessory in violation of the Abortion Con-

[3] See testimony of Drs. Franklin, Gerstley, Osofsky, Klaven and Matthews.

trol Act would have standing to seek a declaratory judgment of the constitutionality of the statute. Cf., *Doe, supra,* 410 U.S. at 189, 93 S.Ct. at 746. However, absent such threatened prosecution, it is more difficult to find that these plaintiffs do have standing. "The sole issue is whether there is a logical link between the status they assert . . . and the claim they seek adjudicated, or between their status and both the type of enactment attacked and the nature of the constitutional infringement alleged." *Doe v. Bolton,* 319 F.Supp. 1048, at 1052 (N.D. Ga. 1970). As referral agencies, plaintiffs attack a criminal statute potentially applicable to them that would subject them to significant criminal penalties; accordingly, we hold they have standing.

Standing is one aspect of justiciability. However, Article III of the United States Constitution limits the jurisdiction of the federal courts to "cases and controversies". It is well established that in actions for declaratory judgments, there must be "exigent adversity"; i.e., an actual controversy in which the constitutionality of the statute is drawn into question in a truly adversary context. See, e.g., *Golden v. Zwickler,* 394 U.S. 103, 89 S.Ct. 956, 22 L.Ed. 2d 113 (1969).

Looking at the evidence of record presently before us, it is clear that the physicians, both individually and as a class, have established a concrete adverseness; for they are the ones whom the Abortion Control Act would *directly* penalize. However, the plaintiff-referral agencies have presented no evidence to support their contention that they may be prosecuted as counsel-conspirators or accessories, and this Court finds, after reading the Act and noting the barren state of the record, that such a conclusion could only

be reached as a matter of pure speculation or conjecture on our part. Consequently, we hold that the claims of the plaintiff-physicians in this case present a justiciable controversy, while the claims of the plaintiff-referral agencies do not. Accordingly, we dismiss as to the referral agencies.

II. Analysis of Roe and Doe

The landmark decisions in the abortion area, which of necessity we must follow in a resolution of the case presently before us, are *Roe v. Wade, supra,* and *Doe v. Bolton, supra.*

Accordingly, we apply the mandate of the Supreme Court to the legislation presently before us. Part of that mandate appears at the end of the opinion in *Roe, supra,* 410 U.S. at 164-66, 93 S.Ct. at 732-33, where Mr. Justice Blackmun stated:

> To summarize and to repeat:
>
> 1. A state criminal abortion statute of the current Texas type, that excepts from criminality only a *life-saving* procedure on behalf of the mother, without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.
>
> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the healh of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

2. The State may define the term "physician", as it has been employed in the preceding paragraphs of this Part XI of this opinion, to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

In *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201, procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together. . . .

[This] decision leaves the State free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intraprofessional, are available.

The language of the *Roe* decision clearly indicates that the Supreme Court reached its decision by making the following determinations: 1) there is a fundamental right to privacy; 2) this right encompasses the pregnant woman's decision to have an abortion; 3) being a fundamental right, the right to an abortion can be limited only by a compelling state interest; 4) the state has a compelling interest in the mother's health which arises approximately at the end of the first trimester of pregnancy; and 5) the state has a compelling interest in the life of the fetus when it become viable.

As the Supreme Court stated in its *Roe* decision, *Roe* should be read in conjunction with *Doe v. Bolton.* Thus in *Doe* the Court invalidated in part a more modern Georgia abortion statute because: 1) with respect to certain statutorily imposed requirements, the challenged statute failed to exclude the first trimester of pregnancy; 2) with respect to certain other statutorily imposed requirements, the state failed to prove that the statutory restriction was rationally connected to the objective the state sought to accomplish; and 3) with respect to other provisions, the statutorily imposed overview caused the abortion procedure to be regulated more strictly than any other medical or surgical procedure.

III. Burden of Proof

One overall issue that pervades this entire case, and which the parties have continually raised, is the question of burden of proof. The Supreme Court's decision in *Roe* clearly states that the pregnant woman's decision to have an abortion is a fundamental right which may be limited only at certain compelling points by legitimate state inter-

ests. In this regard, Mr. Justice Blackmun stated in *Roe, supra,* 410 U.S. at 155, 93 S.Ct. at 728:

> Where certain "fundamental rights" are involved, . . . regulation[s] limiting these rights may be justified only by a "compelling state interest," . . . and . . . [these] legislative enactments must be narrowly drawn to express only the legitimate state interests at stake. . . . [Citations omitted.]

We hold that the burden is on the defendants to show: 1) that there exists a legitimate state interest requiring a legislative enactment, 2) the point at which this legitimate state interest becomes compelling, and 3) that the legislative enactment is narrowly drawn to express only the legitimate state interest in question.

IV. Severability

Plaintiffs contend that the Abortion Control Act "is unconstitutional on its face and in its entirety on the ground that the legislative intent to unconstitutionally limit, deter, and regulate the abortion decision which is expressed in its title, language, and various provisions, vitiates the statute as a whole." Defendants argue: 1) the Act is constitutional, or in the alternative, 2) if any section is unconstitutional the statute's severability clause evidences an express legislative intent that this Court must heed[4]. Clearly

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[4]The relevant provision is as follows:

Section 9. Severability.—

If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

the effect of the sections herein declared unconstitutional is to improperly restrict the exercise of the fundamental right of the pregnant woman, in consultation with her physician, to make the abortion decision at points in time when the state has not demonstrated a compelling interest justifying statutory regulation. We have examined each section of the Act and we have determined, notwithstanding the fact that a number of sections are unconstitutional, that the invalid sections are severable and the Act is not unconstitutional in its entirety. Therefore, we now turn to a section-by-section examination of the Act.

V. Consent to Abortion

Spousal and Parental Consent

Plaintiffs contend "the parental and spousal consent provisions of the Act and the criminal provision associated therewith are unconstitutional and invalid infringements of their rights to privacy. . . ." Defendant Fitzpatrick concedes that Sections 3(b)(i), 3(b)(ii), and 3(e) to the extent that it relates to 3(b), are unconstitutional. However, the state defendants contend the parental and spousal consent provisions are constitutional and evidence the state's legitimate interest in protecting "the long-established inherent rights of spouses and parents concerning the familial unit and child welfare." The challenged provisions are as follows:

> Section 3. Consent to Abortion: Limitations on Public Officials.—
>
> . . . .
>
> (b) No abortion shall be performed upon any person in the absence of the written consent of (i) the spouse of such person provided that the whereabouts

of such spouse can be learned from such person or from other readily available sources and he can be notified and that the abortion is not certified by a licensed physician to be necessary in order to preserve the life or health of the mother, (ii) one parent or person in loco parentis of such person if such person is under eighteen years of age and unmarried unless the abortion is certified by a licensed physician as necessary in order to preserve the life of the mother.

. . . .

(e) whoever performs an abortion and without consent as required in subsections (a) and (b) of this section shall be guilty of a misdemeanor of the first degree. . . .

We find the spousal consent provision of the Act an unconstitutional infringement of a pregnant woman's fundamental right of privacy. Initially, we note that the Supreme Court did not rule directly upon the issues of spousal or parental consent in either *Roe* or *Doe*. Thus in *Roe, supra*, 410 U.S. at 165, 93 S.Ct. at 733, the Court states in a footnote:

> Neither in this opinion nor in *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201, do we discuss the father's rights, if any exist in the consitutional context, in the abortion decision. No paternal right has been asserted in either of the cases, and the Texas and the Georgia statutes on their face take no cognizance of the father. We are aware that some statutes recognize the father under certain circumstances. North Carolina, for example, N.C. Gen. Stat. §14-45.1 (Supp. 1971), requires written permission for

> the abortion from the husband when the woman is a married minor, that is, when she is less than 18 years of age, 41 N.C.A.G. 489 (1971); if the woman is an unmarried minor, written permission from the parents is required. We need not now decide whether provisions of this kind are constitutional.

Though *Roe* and *Doe* do not directly decide the issues of spousal and parental consent, this Court concludes that of necessity these decisions by implication provide the backdrop against which these interests must be viewed. The Supreme Court's analysis in *Roe* clearly states that a woman has a qualified, though not absolute, right to decide to have an abortion. The woman's decision is qualified to the extent that there must be a balancing of her fundamental right of privacy with other important and legitimate interests at specified compelling points. Thus, in *Roe, supra*, 410 U.S. at 162-63, 93 S.Ct. at 731, the Court states:

> In view of all this, we do not agree that, by adopting one theory of life, Texas may override the rights of the pregnant woman that are at stake. We repeat, however, that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the State or a nonresident who seeks medical consultation and treatment there, and that it has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes "compelling."

It is imperative, therefore, that any state regulation in the field of abortion both take cognizance of the woman's fun-

damental right and draw the proper balance between a legitimate state interest and the pregnant woman's interest. The challenged spousal consent provision of the Abortion Control Act is invalid because it does not balance the interest of the pregnant woman with the purported interest, if there is a constitutional one, of the the husband; but rather the provision gives the spouse an unqualified and unconditional veto over the wife's decision to have an abortion, thus completely ignoring the fundamental right of the pragnant woman to make the abortion decision.

A number of other courts have come to the same conclusion and have invalidated statutorily imposed spousal consent provisions. Cf., *Doe v. Doe,* Mass. , 314 N.E. 2d 128 (1974); *Jones v. Smith,* 278 So. 2d 339 (Fla. Ct. App. 1973), *cert. den.,* 94 S.Ct. 1486 (1974); *Coe v. Gerstein,* 376 F.Supp. 695 (S.D. Fla. 1973), *app. dism.* and *cert. den.,* 94 S.Ct. 2246 (1974); *Doe v. Rampton,* 366 F.Supp. 189 (C.D. Utah 1973); *Doe v. Bellin Memorial Hospital,* 479 F.2d 756 (7th Cir. 1973); also see annotation at 62 ALR 3d 1097. We are aware of only one case wherein a spousal consent provision has not been invalidated, however, the Supreme Court has stayed enforcement of that particular statute. See *Planned Parenthood of Central Missouri v. Danforth,* 392 F.Supp. 1362 (E.D. Mo. 1975), *stay grta.,* 95 S.Ct. 1111 (1975).

The spousal consent provision of the Act mandates that a pregnant woman's spouse take the affirmative step of giving his consent before an abortion may be performed. We find this provision, requiring affirmative action, is not narrowly tailored to meet a legitimate interest of either the spouse or the state. Even if this Court were to find that the asserted interests of the husband were protected by the

Constitution, we would still have to take cognizance of the Supreme Court's pronouncement in *Roe,* that the husband's pregnant spouse has a fundamental right to decide to have an abortion, which prior to the second trimester must be "free of interference by the State." *Roe, supra,* 410 U.S. at 164, 93 S.Ct. at 732. We need not decide here whether the husband's interest in the abortion decision is in fact protected by the Constitution. The Supreme Court has determined that the wife's interest in the abortion decision is a fundamental right. Nevertheless, the statute before us requires, in every case, that the wife obtain the consent of her spouse for an abortion; consent is required even if the spouse asserts no interest in the wife or the family, or no paternal interest in the potential child. At least one of the state defendants' witnesses has testified that though it is oft times beneficial for the marital relationship for the husband to be informed and consulted with respect to the abortion decision, nevertheless, he should not be given absolute veto power over the wife's decision[5]. State restrictions on fundamental rights must be narrowly drawn to conform to the legitimate interests to be furthered. *Roe, supra,* 410 U.S. at 155, 93 S.Ct. at 728. Clearly the spousal consent provision of the Act is not narrowly drawn and cannot stand; we declare Sections 3(b) (i) and 3(e) to be unconstitutional.

We also find that the parental consent provision of the Act is an unconstitutional infringement of a minor woman's fundamental right of privacy in violation of the Fourteenth Amendment of the Constitution. We note that other courts have invalidated statutorily imposed parental consent provisions also. Cf., *Foe v. Vanderhoof,* 389

[5]See testimony of Amitai Etzioni.

F.Supp. 947 (D. Colo. 1975); *Baird v. Bellotti*, 393 F. Supp. 847 (D. Mass. 1975); *Coe v. Gerstein*, 376 F.Supp. 695 (S.D. Fla. 1973), *app. dism.* and *cert. den.*, 94 S.Ct. 2246 (1974); *Doe v. Rampton*, 366 F.Supp. 189 (C.D. Utah 1973); *Wolfe v. Schroering*, 388 F.Supp. 631 (W.D. Ky. 1974). Again, we are aware of only one case wherein a parental consent provision has not been invalidated; however the Supreme Court has stayed enforcement of that particular statute. See, *Planned Parenthood of Central Missouri v. Danforth*, 392 F.Supp. 1362 (E.D. Mo. 1975), *stay grtd.*, 95 S.Ct. 1111 (1975).

Initially, we agree with the analysis of the Washington Supreme Court in *State v. Koome*, 84 Wash. 2d 901 530 P.2d 260 (En Banc, 1975), where the Court states at 530 P.2d 263:

> Prima facie, the constitutional rights of minors, including the right of privacy, are coextensive with those of adults. Where minors' rights have been held subject to curtailment by the state in excess of that permissible in the case of adults it has been because some peculiar state interest existed in the regulation and protection of children, not because the rights themselves are of some inferior kind. . . . In some other cases minors' rights have been differentiated from those of adults because of a fundamental difference in the nature of the particular state interaction with juveniles.
>
> ....
>
> Several courts have upheld minors' privacy rights where no such special context or state interest existed. . . . Recognition of the equal status of the rights of minors seems particularly necessary with regard to the privacy rights involved here. . . . [Citations omitted.]

The state defendants argue, however, that the statute's abridgement of fundamental rights is justified by a compelling state interest not asserted in *Roe* and *Doe*. This interest is alleged to be a legitimate state interest in "safeguarding the societal role of parents in the supervision of their unemancipated minor children" and "preserving the family unit."

We agree that, whenever possible, parents should be involved in the medical decisions of unemancipated minor children. However desirable it may be to have parents involved in the abortion decision, it is clear that the state may not destroy the fundamental right of the pregnant minor to make the final decision concerning abortion, provided that she is capable of making an intelligent, informed decision. The Abortion Control Act is not an attempt to encourage parental involvement, rather it destroys the right of the minor to make the abortion decision, without regard for her age, maturity, intelligence or ability to make an informed decision. It is significant that the state defendants' own witnesses do not support the state's view that parents must invariably be involved in the decision of the pregnant minor; for when serving as counselors, defendants' witnesses do not involve the parents without the voluntary permission of the minor[6].

State defendants contend that "although both adults and minors are protected by the Fourteenth Amendment, the state may impose more stringent regulations on the activities of children than it may adopt with respect to

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[6]See testimony of Michael Bradley, Erma Craven and Margaret O'Neill.

adults." In support of this proposition defendants cite to the Court the cases of *Wisconsin v. Yoder*, 406 U.S. 205, 92 S.Ct. 1526, 32 L.Ed. 2d 15 (1972); *Ginsburg v. New York*, 390 U.S. 629, 88 S.Ct. 1274, 20 L.Ed. 2d 195 (1968); and *Prince v. Massachusetts*, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645 (1944). The cases relied on by defendants arise from a factual situation where there was a conflict between the parent and the state as to what was in the best interest of the child. In the instant case, however, we are faced with a clearly distinguishable factual situation where there is merely a potential conflict between the parent and the child as to what is in the best interest of the child. Where there is such a potential conflict between the interests of the child and other possible interests of the parent, the state cannot statutorily mandate that the parent must always prevail, for parental consent may not simply be unilaterally substituted for consent of the child, particularly, where as here, the fundamental right is infringed without affording the child any rights of due process.

Even if we were to agree with state defendants' proposition that the expression of protected rights asserted on behalf of minors may be curtailed or even prohibited, Section 3 (b) (ii) of the Act still could not stand. We note that the state of Pennsylvania enacted the Act of February 13, 1970, P.L. , No. 10, §§1-5[7] entitled "Minors' Consent to Medical, Dental and Health Services." The relevant sections of said Act are as follows:

§10101. Individual consent

Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or

[7] 35 P.S. §10101-10105.

has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

. . . .

§10103. Pregnancy, venereal disease and other reportable diseases

Any minor may give effective consent for medical and health services to determine the presence of or to treat pregnancy, and venereal disease and other diseases reportable under the act of April 23, 1956 (P.L. 1510), known as the "Disease Prevention and Control Law of 1955," *and the consent of no other person shall be necessary.* [Emphasis added.]

Thus, at present a pregnant minor who chooses to give birth may receive all necessary medical treatment without the consent of her parents, as a matter of Pennsylvania statutory law. Yet Section 3 (b) (ii) of the Act would require a pregnant minor who chooses to abort to obtain parental consent before she could receive medical treatment to terminate the pregnancy. Such a distinction is clearly inconsistent with *Roe* and *Doe* because this section of the Act singles out the abortion procedure as it applies to minors and places an extra layer of restrictions upon the effectuation of a minor's fundamental right to choose to have an abortion.

Furthermore, the parental consent provision before us is not narrowly tailored to meet the alleged state interest in protecting the parents role in supervising their unemancipated minor children. As the Court in *State v. Koome, supra*, 530 P.2d at 265, recently observed in striking down a similar provision:

> In the circumstances envisioned by this statute there seems to be little parental control left for the State to help salvage. An unmarried minor has become pregnant, and her determination to get an abortion is unalterably opposed by her parents. Reestablishment of parental control by resort to the pure force of the criminal law seems both futile and manifestly unwise in such a situation. . . .

Finally, the asserted state interest in ensuring that the minor's decision be informed does not justify the parental consent provision of the Act. Under the terms of the Act, parental consent is mandated under every circumstance except where "necessary in order to preserve the life of the mother." Thus, a minor must obtain parental consent even if carrying to term endangers her health. The provision here in question is overbroad for it provides an absolute parental veto where less restrictive means are available to ensure that the minor's decision is a "knowing and intelligent" one.[8]

Accordingly, for the reasons stated above, we declare Sections 3(b) (ii) and 3(e) to be inconsistent with the Supreme Court's decisions in *Roe* and *Doe*, and therefore unconstitutional.

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[8]The physician-patient consultation that should precede any abortion provides information, advice as to alternatives, and time for deliberation. Moreover, Pennsylvania common law requires that physicians determine that a minor's decision to consent to any form of medical care is both adequately informed and considered; civil liability is available to enforce this requirement. See, e.g., Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970) and cases cited therein.

VI. Protection of Life of Fetus

A. Viability and Potential Viability

Viability as defined in Section 2 and made operative by the Act, with criminal sanctions provided, is challenged by the plaintiffs as being unconstitutionally vague and overbroad in that as it is used in Section 5 it infringes the fundamental right of the pregnant woman to decide in consultation with her physician to have an abortion, without concern for potential fetal life, at any time prior to the 24th week of gestation. However, defendants contend that since the Act leaves the determination of viability to the physician's best medical judgment, it comports with the prevailing constitutional standards of *Roe* and *Doe* and embodies the state's important interest in protecting the life of the fetus. The challenged sections are as follows:

> Section 2. Definitions.—As used in this act.
> . . . .
>
> "Viable" means the capability of a fetus to live outside the mother's womb albeit with artificial aid.
>
> Section 5. Protection of Life of Fetus.—
>
> (a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion

technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

. . . .

(d) Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section, . . . shall be subject to such civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted.

The Act defines viability as "the capability of a fetus to live outside the mother's womb albeit with artificial aid." Plaintiffs contend there is a difference of opinion among physicians as to the period of gestation indicated by the statutory definition in question. Defendants contend that in *Roe*, the Supreme Court recognized that viability occurred when the fetus was "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe, supra*, 410 U.S. at 160, 93 S.Ct. at 730. Thus defendants argue that a definition in keeping with the aforementioned pronouncement of the Supreme Court cannot be considered vague. The issue then is whether or not the Supreme Court intended to limit its holding concerning viability to the quoted language urged by defendants; for we note the Court stated in the very next sentence: "Viability is usually placed at about 7 months (28 weeks) but may occur earlier, even at 24 weeks." *Roe, supra*, 410 U.S. at 160, 93 S.Ct. at 730.

Defendants also argue that there is a "common medical consensus as to the meaning of the term 'viability' and the methods uniformly used by the medical community in determining such." We note that testimony of witnesses, affidavits and depositions were offered by both parties on this issue. We believe that a preponderance of the evidence supports a finding that there is not a consensus within the medical community as to the gestational age at which viability occurs. Moreover, viability as defined in the Act, without reference to gestational age, is confusing even to members of the medical profession. The testimony of record does not indicate a consensus within the medical community as to the meaning of viability as defined by the Act; but rather there is only a consensus as to the method for determining gestational age. Thus, the physicians who testified agreed that gestational age was determined by the physician using his best judgment in correlating the menstrual history of the particular pregnant woman with his findings from a physical examination of the pregnant woman. It is clear from the evidence that while not every physician would reach exactly the same determination as to gestational age, there would be a consensus within reasonable and tolerable limits.

The ability of a fetus to live outside the mother's womb cannot be determined directly. To reach such a judgment physicians must correlate certain probability of survival factors with the gestational age to determine viability as defined by the Act. The evidence clearly demonstrates that the statistical data available to the physician concerning fetus survival is not precise; also other variables such as the mother's health and the quality of hospital facilities in the community must be taken into consider-

ation. There is a lack of consensus within the medical community as to "the capability of a fetus to live outside the mother's womb albeit with artificial aid" when the gestational age of the fetus is determined to be between 20 and 28 weeks. The closer gestational age is to 20 weeks, the greater is the probability that the fetus cannot live outside the mother's womb; the closer gestational age is to 28 weeks, the greater is the probability that the fetus can live outside the mother's womb. The inability of physicians to agree in this area is demonstrated by the fact that Dr. Franklin, a plaintiff, believed that the statistical probabilities dictated a finding that viability would only occur at approximately 28 weeks, based upon a 10 percent probability of survival rate for fetuses of 28 weeks gestation. Dr. Gerstley, who also appeared on behalf of plaintiffs, did not completely agree with Dr. Franklin's analysis and set 24 weeks as the minimum period necessary for viability. Similarly, physicians presented on behalf of defendants did not agree among themselves nor with the plaintiffs' physicians. Thus Dr. Keenan placed viability at 26 weeks, based upon a 10 to 30 percent probability of survival rate for fetuses of 26 weeks gestation. A fair reading of the testimony of another physician called by the defendants, Dr. Mecklenburg, demonstrates that he would reach the conclusion that viability occurred at 20 weeks gestation[9].

[9]The specific testimony of Dr. Mecklenburg concerning this issue was as follows:

Mr. Morris: Doctor, as one who performs abortions I want to read you a sentence and ask you what it means to you. The sentence is, "Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid" . . . .

Dr. Mecklenburg: I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact that it is constantly changing. My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks—not in the current edition of Eastman's Obstetrics Book, but in the previous edition, the earliest report a survivor was reported as a delivery at 20 weeks gestation. In my own experience I have—the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal. (Tr. 1/14/75, pp. 82-3.)

Defendants argue at page 38 of their post-trial brief that viability can only be said to exist with absolute certainty at 26 to 28 weeks gestation and the Abortion Control Act does not prohibit an abortion prior thereto. Of course, this is counsel's interpretation of the statute and not the language of the statute. Indeed, if the statute had even limited viability to 24 weeks gestation, it would be in conformity with the pronouncement of *Roe*, and not subject to a successful challenge. Nevertheless, we must decide the issue before us on the basis of the statute as written, rather than as interpreted by counsel.

In considering the facial validity of the challenged definition of viability of the Abortion Control Act, and Section 5 as it incorporates the definition, we are guided by the analysis of Mr. Justice Marshall found in *Grayned v. City of Rockford*, 408 U.S. 104, at 108-9, 92 S.Ct. 2294, at 2298-9, 33 L.Ed. 2d 222 (1972):

> It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is

free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abut[s] upon sensitive areas of basic first amendment freedoms," it "operates to inhibit the exercise of [those] freedoms." Uncertain meanings inevitably lead citizens to "'steer far wider of the lawful zone' . . . than if the boundaries of the forbidden areas were clearly marked." [Footnotes omitted.]

We find that the Abortion Control Act's definition of viable is vague because it does not notify physicians as to what conduct on their part is prohibited. We have carefully considered the arguments of defendant and particularly the contention that while the legislature could have defined the standard for prohibited conduct in terms of gestational age, it was entitled to define it as set forth in the Act, especially where the definition in the Act will continue to be valid even when advances in the medical profession lower the gestational age for viability. Of course, the very flexibility argued for by defendants contributes to the vagueness of the Act. Moreover, the Act may reasonably be interpreted in the medical community as setting viability

at a substantially lower gestational age than the 26 to 28 weeks which defendants' counsel contends it presently sets.

Plaintiffs also argue that the vagueness of the definition of viability subjects them to possible arbitrary and discriminatory prosecution. The evil is one recognized by Justice Marshall in *Grayned v. City of Rockford, supra,* where he states at 408 U.S. 108-9, 92 S.Ct. 2299: "A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application." We believe that such a danger exists here for, without an objective standard to guide law enforcement officers, prosecutors and courts, physicians will be subject to prosecution controlled only by the subjective determinations of those charged with law enforcement. The possibility of such arbitrary enforcement certainly will, as plaintiffs contend, inhibit and deter physicians from performing abortions after a fetus has reached the gestational age of 20 weeks. Such a limitation prior to the 24th week of gestation is inconsistent with the fundamental right of a pregnant woman to obtain an abortion without regard to the potential for fetal life within the second trimester of the pregnancy. We find that the Supreme Court in *Roe* intended to set the lowest limit at which viability may be deemed to occur at the 24 week period. Accordingly, we hold that Section 2's definition of viability, Section 5 (a) of the Act, which incorporates that definition, and Section 5 (d), which imposes civil and criminal sanctions, are inconsistent with *Roe,* and are therefore unconstitutional.

In addition to challenging the definition of viability as being vague, plaintiffs also challenge the right of the

legislature to regulate the procedure used where the fetus "may be viable", as evidenced by the language of Section 5(a) and enforced by Section 5(d) of the Act. *Roe* makes it abundantly clear that the compelling point at which a state in the interest of fetal life may regulate, or even prohibit, abortion is not before the 24th week of gestation of the fetus, at which point the Supreme Court recognized the fetus then presumably has the capability of meaningful life outside the mother's womb. Consequently, *Roe* recognizes only two periods concerning fetuses. The period prior to viability, when the state may not regulate in the interest of fetal life, and the period after viability, when it may prohibit altogether or regulate as it sees fit. The "may be viable" provision of Section 5(a) tends to carve out a third period of time of potential viability. Defendants' witness, Dr. Keenan, testified that based upon his interpretation of Act 209, the Act's definition of potential viability occurs at 20 to 26 weeks gestation. (See Tr. 1/17/75, p. 549.) It is clear that in carving out this new time period labeled "may be viable" the state is regulating abortions during the second trimester, when it may lawfully do so only in the interest of maternal health. Yet the state does not claim the provision to be in the interest of maternal health, nor has it shown any connection between this provision concerning fetuses which "may be viable" and maternal health. Clearly, the state seeks to justify this provision only as a measure in furtherance of its claimed interest in protecting potentially viable fetuses. Since this provision does not meet the requirements of *Roe*, we declare it to be unconstitutional.

In reaching our conclusion concerning the issue of viability as defined; and as incorporated in Section 5(a),

we have considered two cases which defendants have cited as upholding similar definitions of viability: *Wolfe v. Schroering*, 388 F.Supp. 631 (W.D. Ky. 1974) and *Planned Parenthood of Central Missouri v. Danforth*, 392 F.Supp. 1363 (E.D. Mo. 1974), *stay grtd.*, 95 S.Ct. 1111 (1974). After examining *Wolfe* and *Danforth* we are not persuaded by the reasoning of the three-judge courts in either case, but rather we are bound to follow the mandate of the United States Supreme Court in *Roe* and *Doe*. Our decision herein is consistent with the holdings of several other courts. See, for example, *Hodgson v. Anderson*, 378 F.Supp. 1008 (D. Minn 1974), *appeal dismissed*, 95 S.Ct. 819 (1975); and *Leigh v. Olson*, 385 F.Supp. 255 (D. N.D. 1974).

B. Disposition of Dead Fetuses

Plaintiffs attack Section 5(d) of the Act which requires the Department of Health to make regulations to provide for the humane disposition of dead fetuses. Plaintiffs contend that this provision is an overbroad unconstitutional invasion of the pregnant woman's right of privacy with respect to pregnancies terminated during the first and second trimesters, wherein the only compelling state interest relates to maternal health in the second trimester. Defendants respond to plaintiffs' attack with the argument that "the section in question in no way burdens the exercise of a constitutional right but instead expresses a clear state interest in public health and welfare." The challenged provision is as follows:

Section 5. Protection of Life of Fetus.—

. . . .

(c) The department shall make regulations to provide for the humane disposition of dead fetuses.

. . . .

Plaintiffs' challenge to this section is based on a fear that future adopted regulations will require elaborate funeral provisions, treating the fetus as a human, and that psychologically and financially such regulations will burden a pregnant woman's decision concerning abortion. At the time of trial, plaintiffs made it clear that they did not question the right of the Department of Health to make regulations concerning the disposition of live tissue. The following statement by counsel for the plaintiffs sets forth plaintiffs' position in this regard:

> As far as the department's ability to make regulations as to disposition of live tissue generally, or for that matter with respect to disposition of fetal tissue for purposes of laboratory studies and such, that's no problem, but that power already exists more than amply under the general powers of the Department of Health, which are extremely broad.
>
> So we are not, and there is no issue here of preserving a power which the Department of Health would not otherwise possess. (Tr. 1/15/75, p. 166.)

In addition the state, in its post-trial brief notes that the plaintiffs do not object

> to incineration of dead fetuses. Certainly, no argument is made regarding fears expressed by plaintiffs on burial requirements. The Commonwealth would submit that the reasonable intent of the Act is to preclude the mindless dumping of aborted fetuses on to garbage piles. . . . . [Thus,] the obvious public health considerations regarding sanitation, disease prevention and surgical standards more than amply justify the requirement of Section 5 (a).

We view the particular provision in question as being merely an enabling statute which is not unconstitutional on its face. We believe that the state in the constitutional exercise of its police power may provide for the disposition of dead fetuses to protect the public health. The language of the statute which troubles plaintiffs is that it requires the *humane* disposition of dead fetuses. Of course, a regulation that requires expensive burial may very well invade the privacy of the pregnant woman and burden her decision concerning an abortion. However, no such regulation has been adopted to date pursuant to Section 5 (c), and we find that this section is not unconstitutional on its face. We, of course, do not foreclose a future challenge to any unconstitutional regulation adopted pursuant to this section.

VII. Control of Practice of Abortion

A. Pregnancy Determination

Section 6 of the Act is concerned with the control of the practice of abortion. Plaintiffs challenge Section 6 (a), which is criminally enforced by Section 6 (i), to the extent that it requires a positive determination of pregnancy prior to the performing of an abortion. Defendants respond by arguing that the positive pregnancy determination requirement manifests a compelling state interest in maternal health. The challenged provision is as follows:

Section 6. Control of Practice of Abortion.—

(a) Every person who intends to perform or induce an abortion shall first have made a determination of the pregnancy of the person to be aborted.

. . . .

At page 52 of their post-trial brief, the plaintiffs concede ". . . physicians agree that it is desirable to have positive pregnancy indications prior to undertaking an abortion procedure on the grounds that, generally, individuals should not be subjected to medical procedures without a clear indication of the requirement therefore, . . ." However, notwithstanding this concession, plaintiffs argue that "under certain circumstances the procedure known as menstrual extraction can be, and desirably is, performed prior to the time when [an] average facility can determine with absolute certainty whether or not the patient is pregnant." Thus, plaintiffs only factual reason for challenging this section is that occasionally a patient may seek an abortion by menstrual extraction within the first few days of pregnancy, and at that time a reliable test for determining pregnancy is not available outside of Philadelphia County.[10]

There appears to be substantial agreement between the parties that a menstrual extraction is an abortion procedure and that there are possible risks to the health of the

[10]Plaintiffs agree with defendants that Planned Parenthood, in a program in cooperation with Jefferson Hospital of Philadelphia, can obtain a positive testing within the first few days of pregnancy by a radio immuno assay. Also, apparently there is no question that residents of surrounding counties in the Eastern District of Pennsylvania could also receive such testing through the facilities of Planned Parenthood or Jefferson Hospital.

female patient from infection and hemorrhage. An additional relevant factor in our determination in this area is the response of plaintiffs' witness, Dr. Matthews, to questions put to him by defense counsel on cross-examination:

Mr. Mansmann: Now, you had testified about a menstrual extraction, and you performed them at your clinic; is that right?

Dr. Matthews: Yes.

Mr. Mansmann: Is it your medical opinion that it would be better for a woman to see whether or not she is pregnant before she undergoes a menstrual extraction, or does it make any difference?

Dr. Matthews: I am not overjoyed with menstrual extraction as a procedure. Because if you do them within one week of the last missed period, probably only about 50 to 55 percent of them will be pregnant. (Tr. 1/14/75, p. 126.)

In sum, it is plaintiffs' contention that even though a prior determination of pregnancy is desirable before an abortion procedure is performed, Section 5 (a) of the Act is unconstitutional because it is not limited to the period following the first trimester of pregnancy, when the state may lawfully regulate abortions in the interest of maternal health. However, plaintiffs do concede that preventing non-pregnant women from undergoing abortion procedures is in the interest of female health.

We believe *Roe* mandates that once a pregnancy has been determined to exist, the state may not regulate in the interest of maternal health during the first trimester of pregnancy. Nevertheless, we do not believe that *Roe* precludes the state from requiring a positive determination of

pregnancy prior to the performance of an abortion procedure in furtherance of its interest in protecting nonpregnant females from undergoing unneeded abortion procedures. We do not believe that the Supreme Court intended by its *Roe* protection of pregnant females to preclude the statutory protection of nonpregnant females in the manner here challenged. Accordingly, we hold that Section 6 (a) is constitutional.

B. Performance of Abortion Subsequent to Viability

Plaintiffs challenge Section 6 (b) of the Act, which is criminally enforced by 6 (i), to the extent that it incorporates the definition of viability found in Section 2 of the Abortion Control Act. Defendants respond by arguing that the definition of viability is in accord with *Roe,* and embodies the state's interest in protecting the potential life of the fetus. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> . . . .
>
> (b) No abortion shall be performed within the Commonwealth of Pennsylvania during the stage of pregnancy subsequent to viability of the fetus except where necessary, in the judgment of a licensed physician, to preserve the life or health of the mother.
>
> . . . .

Plaintiffs acknowledge the right of the state to prohibit abortions subsequent to viability but attack the definition of viability for the reasons hereinbefore set forth in our analysis of Section 2 and Section 5 of the Act. We have hereinbefore determined that the Act's definition of viability is unconstitutionally vague; accordingly, Section 6

(b), which incorporates that infirm definition, is declared to be unconstitutional.

C. Abortion Facility Approval

Plaintiffs challenge Section 6 (c), which is criminally enforced by Section 6 (i), to the extent that it requires an abortion to be performed in a facility approved by the Department of Health. Citing as authority the cases of *Nyberg v. City of Virginia,* 495 F.2d 1342, at 1345 (8 Cir. 1974); *Word v. Poelker,* 495 F.2d 1349 (8 Cir. 1970); and *Hodgson v. Anderson,* 378 F.Supp. 1008, at 1016 (D. Minn. June 27, 1974), plaintiffs contend that this provision is unconstitutional because no regulation of abortion may take place in the first trimester and the statute fails to take cognizance of the separate trimesters of pregnancy. Defendant Fitzpatrick concedes that Section 6 (c) is unconstitutional insofar as it requires facility approval with respect to first trimester abortions. However, the state defendants contend that the provision in question is constitutional because state regulation in this area is related to the state's legitimate interests in protecting maternal health and would not intrude on the abortion decision. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> . . . .
>
> (c) No abortion shall be performed within the Commonwealth of Pennsylvania except by a licensed physician and in a facility approved to do so by the Department of Health in accordance with its rules and regulations.
>
> . . . .

We note that the Department of Health has not presently adopted any regulations pursuant to this provision of the Act. It is admitted by plaintiffs that the Pennsylvania Department of Health, after public hearings, issued regulations governing free standing abortion clinics prior to the enactment of the Act. It is further admitted that hospitals are facilities approved by the Department of Health and that the regulations adopted prior to the enactment of the Act do not instrude upon the decision of whether or not to abort, or the decision of how to abort. Finally, it is admitted that the present Health Department's regulations do not constitute an invasion into the physician-patient relationship and that these regulations do not intrude upon the woman's right of privacy. (See Tr. 1/17/75, pp. 521-522.) Thus, the question concerning the constitutionality of Section 6(c) is tendered to us with a clear record of regulation in the area by the Department of Health pursuant to its general powers. It is undisputed that no regulations have as yet been promulgated pursuant to Section 6(c) of the Act.

Plaintiffs succinctly state their position with respect to this provision in their post-trial brief at page 56 as follows:

> Plaintiffs do not challenge reasonable regulations of abortion promulgated under the general powers of the Department of Health, and we do not believe that the validity of the abortion regulations promulgated prior to the enactment of this statute is at issue here. However, we contend that the provisions of the present Act with regard to regulation of abortion should be struck down. To the extent that they reflect the legislative attempt to "conrol" abortion they are unconstitutional. To the extent that they merely purport to enable the Department to promulgate reasonable regulations to protect maternal health, they are not supported by any legitimate state purpose, since they are redundant of the Department's general powers.

From the record in this case and the statements of counsel in their post-trial brief, it is indeed open to question whether or not there is a real challenge by plaintiffs to this particular provision of the Act, and accordingly, whether there is a justiciable controversy presently before the Court in this regard. However, we consider plaintiffs' challenge to be that an act which authorizes the future adoption of regulations in this area is unconstitutional on its face, if it does not also provide that the regulations only apply to abortions performed after the first trimester. We do not believe that the provision in question is unconstitutional on its face, nor do we believe that it is inconsistent with either *Roe* or *Doe* in merely authorizing regulations. Of course, any regulations promulgated in the future must be consistent with the requirements of the Supreme Court.[11] Accordingly, we declare Section 6(c) not to be unconstitutional on its face and deny plaintiffs' request for injunctive relief.

D. Information to be Reported Concerning Abortions

Plaintiffs challenge Section 6(d) of the Act, which is criminally enforced by Section 6(i), to the extent that it requires information relating to whether the abortion was necessary to preserve the mother's life or health, and the

[11]For a more recent, post-Roe decision in this area, see Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), cert. den., 95 S.Ct. 1438 (1975).

spousal and parental consent provisions hereinbefore declared to be unconstitutional. These consent provisions are found in Section 3 of the Act. Defendant Fitzpatrick concedes that the spousal and parental consent provisions of the Act are unconstitutional; however, the state defendants contend that both the spousal and parental consent provisions and Section 6(d) of the Act are constitutional. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> ....
>
> (d) Every facility in which an abortion is performed pursuant to this act within the Commonwealth of Pennsylvania shall currently make and keep on file upon forms prescribed by the Department of Health a verified statement signed by the person who performed the abortion setting forth the following information with respect to such abortion: . . . the name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; the approximate age, in months of the fetus; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother. Affixed to such statement shall be a copy of each of the documents showing consent to abortion as required by section 3 of this act. . . .

Section 6(d) of the Act mandates the reporting of information which is directly related to Section 3(b)(i), 3(b)(ii), and 6(b). However, we have declared the requirements of spousal consent found in Section 3(b)(i) and parental consent found in Section 3(b)(ii), and the performance of abortion requirements found in Section 6(b), to be unconstitutional. Accordingly, we declare unconstitutional the reporting requirements of Section 6(d) that seek information as to:

> [T]he name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; . . .; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother.

E. Prohibition Against Abortion Advertising

Plaintiffs challenge Section 6(f) of the Act, which is criminally enforced by Section 6(i), to the extent it deprives physicians of their rights to free speech, due process of law, and equal protection of the law. Defendants urge that the Act's "ban on abortion advertising narrowly prohibits commercial solicitation in the medical health field in accord with prevailing constitutional authority." The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> ....
>
> (f) No physician, clinic or other person or agency shall engage in solicitation or advertising having the purpose of inviting, inducing or attracting members of the public to come to such physician, or to purchase abortifacients.
>
> ....

Plaintiffs in their post-trial brief at page 54 contend, and we find, "the evidence in this case indicates that a class-plaintiff, Dr. Marshall Klavan, has subscribed to and desire[s] to publish yellow page advertising and to provide information to referral service agencies with the purpose of inducing members of the public to utilize the services of his clinic . . ."

Defendant Fitzpatrick argues that the plaintiffs "cannot complain of a statute which merely enacts the self-imposed limitation of the medical community." Nevertheless, defendant Fitzpatrick "would agree that yellow page listings would not constitute reprehensible advertisement so long as those listings comported substantively with the above mentioned standards." Thus, the position of defendant Fitzpatrick is that a yellow page listing, such as plaintiffs seek, does not violate the medical community's Canons of Ethics.

The state defendants, on the other hand, defend the solicitation or advertising ban of the Act even as to the dissemination of the information proposed by Dr. Klavan. Moreover, the state defendants deny that plaintiffs have standing to raise the First Amendment issue presently before us; and alternatively, argue that even if plaintiffs have standing, the relief requested, should be denied because "a clear line of constitutional authority exists in the First Amendment area recognizing the power of the government to regulate commercial advertising."

Subsequent to final hearing in this matter, the United States Supreme Court decided the case of *Bigelow v. Commonwealth of Virginia,* U.S. , 43 U.S.L.W. 4734 (June 16, 1975). Under the test set forth in *Bigelow,* it is clear that plaintiffs have asserted a legitimate First Amendment interest and have standing to challenge Section 6(f) of the Act as being facially overbroad. The Supreme Court stated in *Bigelow, supra,* 43 U.S.L.W. at 4736: "We give a defendant standing to challenge a statute on grounds that it is facially overbroad, regardless of whether his own conduct could be regulated by a more narrowly drawn statute, because of the 'danger of tolerating, in the area of First Amendment freedoms, the existence of a penal statute susceptible of sweeping and improper application'. *NAACP v. Button,* 371 U.S., at 433."

In *Bigelow,* Mr. Justice Blackmun in his opinion for the Court said: "The Court has stated that 'a State cannot foreclose the exercise of constitutional rights by mere labels'. *NAACP v. Button,* 371 U.S., at 429. Regardless of the particular label asserted by the State—whether it calls speech 'commercial' or 'commercial advertising' or 'solicitation'—a court may not escape the task of assessing the First Amendment interest at stake and weighing it against the public interest allegedly served by the regulation. . . ."

Thus, contrary to the state defendants' contention, merely applying a label "commercial solicitation" does not justify narrowing the protection of expression secured by the First Amendment; particularly where the activity advertised is not illegal, nor in violation of professional ethics, and, where as here, the activity advertised pertains to the constitutionally protected interests of pregnant women who may desire the information in the exercise of their fundamental right to decide to have an abortion.

In support of Section 6(f), the state defendants contend that the provision in question furthers the state's interest in protecting maternal health. Yet the state has failed

to prove in any rational manner how the satutory prohibition of the proffered information would promote its asserted interest in maternal health. Clearly the First Amendment interests at stake here outweigh the asserted interests of the state; accordingly, we declare Section 6 (f) to be unconstitutional.

F. Criminal Sanctions

Plaintiffs challenge Section 6 (i) of the Act to the extent it subjects physicians and others to criminal penalties for the violation of Sections 6 (a) to 6 (f). The challenged section is as follows:

> Section 6. Control of Practice Abortion.—
>
> . . . .
>
> (i) Any person or agency who violates any of the provisions of subsection (a), (b), (c) or (g) of this section is guilty of a misdemeanor of the first degree and any person or agency who violates any of the provisions of subsection (d), (e) or (f) of this section is guilty of a misdemeanor of the third degree.

In conformity with this Court's above determination that Sections 6 (b), 6 (d) in part, and 6 (f), are unconstitutional we declare that Section 6 (i) of Act 209 is unconstitutional to the extent that it ascribes criminal penalties for the violation of Section 6 (b), or the infirm portion of Section 6 (d), and 6 (f).

VIII. Subsidizing of Abortions

Section 7 of the Abortion Control Act is concerned with the subsidizing of abortions. Plaintiffs attack this section on the grounds that it: 1) "imposes an unconstitutional limitation upon the right of medically indigent

women to determine with their physician to terminate a pregnancy during the first two trimesters, 2) classifies women on the basis of wealth with regard to the medical standards for abortion, and 3) discriminates against medically indigent who choose abortion by failing to pay for their medical treatment while paying the full cost of the medical treatment of women who choose childbirth," allegedly in violation of Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and the Equal Protection Clause of the Fourteenth Amendment. Defendant Fitzpatrick concedes the unconstitutionality of this section. However, the state defendants contend this provision is constitutional because: 1) the fundamental right to decide to terminate a pregnancy by abortion does not include a fundamental right that requires the state to pay for the abortion, and 2) in an effort to conserve limited state resources, the state has a legitimate interest in paying only for the more "important and medically necessary services." The challenged section is as follows:

> Section 7. Subsidizing of Abortions.—
>
> Since it is the public policy of the Commonwealth not to use public funds to pay for unneeded and unnecessary abortions, no abortion shall be subsidized by any State or local governmental agency in the absence of a certificate of a physician, filed with such body, stating that such abortion is necessary in order to preserve the life of health of the mother.
>
> Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations made by the Commonwealth or a local governmental agency to hospitals for their maintenance and oper-

ations, or for reimbursement to hospitals for services performed.

With respect to plaintiffs' challenge concerning an alleged discrimination against the indigent pregnant female who chooses abortion, we note that the plaintiffs make two basic attacks on Section 7: 1) the provision is inconsistent with the Social Security Act, and therefore invalid under the Supremacy Clause, and 2) the provision violates the Equal Protection Clause by creating an unlawful distinction between indigent women who choose to carry their pregnancies to birth and indigent women who choose to terminate their pregnancies by abortion. This Court being mindful of the Supreme Court's preference for statutory resolution of cases, as opposed to constitutional resolution of cases, will first consider the challenged provision on the basis of Title XIX of the Social Security Act. See *Hagans v. Lavine*, 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed. 2d 577 (1974).

State defendants admit that it is the policy of the state of Pennsylvania, with respect to its Title XIX program, to pay the full costs of term delivery for eligible women. It is also the policy of the state, as evidenced by Section 7 of the Act, not to pay any of the costs of an abortion for eligible women, unless the abortion is necessary in order to preserve the life or health of the mother.

One of the questions before us is whether Pennsylvania's policy governing payment for the costs of abortions is compatible with Title XIX? Subsequent to the trial in this matter, the U.S. Court of Appeals for the Third Circuit decided the case of *Doe v. Beal*, Nos. 74-1726 and 74-1727 (3d Cir. July 21, 1975) (en banc). In *Doe v. Beal, supra*, the Third Circuit held that a non-statutory state policy prohibiting payment for non-therapeutic abortions[12] is in conflict with Title XIX of the Social Security Act. Accordingly, we apply the law of the Circuit and enjoin the enforcement of Section 7 of the Act insofar as it restricts the payment of Title XIX funds for the costs of an abortion.

However, Section 7 of the Act does not confine itself to Title XIX funds, but rather it applies to any subsidy from a state or local governmental agency. Therefore, our above resolution of the statutory challenge to Section 7 does not completely dispose of the matter, and we must now determine plaintiffs' constitutional challenge to the section.

Plaintiffs contend that since pregnant women have only the option of either birth or abortion, a distinction between indigent pregnant women who choose to carry their

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[12]As discussed in Doe v. Beal, supra, the state's policy under its Medical Assistance program prior to the enactment of the Abortion Control Act was that abortions would only be paid for in the following situations:

1. There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;

2. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or

3. There is documented medical evidence that a continuance of a pregnancy resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient;

4. Two other physicians chosen because of their recognized professional competency have examined the patient and have concurred in writing; and

5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

pregnancies to birth and indigent pregnant women who choose to terminate their pregnancies by abortion, deprive women who choose abortion of their rights guaranteed by *Roe* and the Equal Protection Clause of the Fourteenth Amendment.

The state admits that it provides medical payments for indigent women who carry to term, but not for indigent women who choose to terminate their pregnancy by abortion. Under the Act, an indigent pregnant woman, who is refused medical assistance for a first trimester abortion, may proceed to give birth and the state will pay the reasonable medical expenses incident to the birth. We observe that in this situation the state pays a greater sum of money and clearly does not "conserve limited state resources."

Thus, without realizing any fiscal savings for the state, the Act coerces some pregnant women into a decision to give birth. Of course, we realize that not all pregnant women will forfeit their right to obtain an abortion and some may in fact obtain the abortion without the use of state funds. We note that the state has not attempted to justify Section 7 by arguing that it is less expensive for a pregnant woman to carry to term than for her to have an abortion, and the evidence of records suggests the contrary. Another three-judge court in this Circuit has also concluded that childbirth is costlier than abortion. *Doe v. Wohlgemuth,* 376 F.Supp. 173, at 187 (W.D. Pa. 1973), *aff'd. on other grounds, Doe v. Beal, supra.*

The principal state contention is that "the existence of a fundamental right to decide to have an abortion is not sufficient to order that the means to implement the decision be provided by the State." Thus the argument of Pennsylvania is that the Constitution does not require the state to finance the exercise of a fundamental right. We agree with this general proposition of law, but it does not resolve the issue before us. The issue is whether Pennsylvania may make the exercise of a fundamental right, i.e. a decision to have an abortion, the operative factor in cutting off medical benefits to indigent pregnant women, while continuing benefits to those who decide to give birth. We hold that Section 7 of the Act which penalizes the decision to have an abortion is unconstitutional.

As a threshold matter, we determine that the appropriate standard by which Section 7 is to be measured is the compelling state interest test and not the rational relationship test. The determination by the Supreme Court in *Roe* that it is only when the state interest reaches certain compelling points that the state may regulate with respect to maternal health and fetal life clearly suggests that any state regulation, which burdens the right of the pregnant woman to decide whether to give birth or to terminate a pregnancy, must be necessary to promote a compelling governmental interest. Indeed, the Supreme Court has determined in both pre-*Roe* and post-*Roe* decisions that the compelling state interest test must be applied when fundamental rights are infringed. *Shapiro v. Thompson,* 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed. 2d 600 (1969) and *Memorial Hospital v. Maricopa County,* 415 U.S. 250, 94 S.Ct. 1076, 39 L.Ed. 2d 306 (1974).

In *Shapiro,* the Supreme Court found unconstitutional state statutes denying welfare assistance to residents who had not resided within the jurisdiction for at least one year immediately preceding their applications for public assistance. The Court in deciding that the com-

pelling interest test applied stated at 394 U.S. 634, 89 S.Ct. 1331:

> At the outset, we reject appellants' argument that a mere showing of a rational relationship between the waiting period and the . . . permissible state objectives will suffice to justify the classification . . . the waiting period provision denies welfare benefits to otherwise eligible applicants solely because they have recently moved into the jurisdiction. But in moving from state to state or to the District of Columbia appellees were exercising a constitutional right, and any classification which serves to penalize the exercise of that right, unless shown to be necessary to promote a compelling governmental interest, is unconstitutional.

In the post-*Roe* decision, of *Memorial Hospital v. Maricopa County, supra,* the Supreme Court has recently reaffirmed the principle of *Shapiro.* In *Maricopa County* a durational county residence requirement for eligibility for non-emergency free medical care for indigents was measured by the compelling state interest test and was held to be unconstitutional.

Here, as in *Shapiro* and *Maricopa County,* we deal with governmental benefits for indigents. Here, we deal with a particular subclass of indigents, those who are pregnant. Here as in *Shapiro* and *Maricopa County,* those indigent pregnant women who exercise a right protected by the Constitution, i.e. to have an abortion, are denied the governmental benefit solely as a consequence of the exercise of that right. Accordingly, in reliance on *Roe, Shapiro,* and *Maricopa County,* we hold that although an indigent pregnant woman may not have a fundamental

right to require the government to subsidize an abortion where the state so classifies as to deprive particular indigents of the benefits otherwise available, as a consequence of their exercise of a fundamental right, the state legislation must be measured by the compelling state interest test and the state must demonstrate that its classification scheme promotes a legitimate governmental objective.

The only objective asserted by the state is that its scheme of medical reimbursement is designed to pay only for the more "important and medically necessary services," in an effort to conserve limited state resources. The state does not contend that the costs associated with an abortion are greater than the costs associated with birth, rather the state argues that birth is somehow more medically necessary than abortion. In todays society all pregnant women need medical treatment regardless of whether the women's decision is to give birth or to terminate the pregnancy. There is no physiological or psychological basis in the case of a pregnancy to label the medical services attendant to birth more important or necessary than those attendant to abortion. The language of the statute indicates that the distinction here contended for by Pennsylvania rests upon a social policy preference and not a medical determination. Of course, a statute which discriminates in terms of illegal classifications and penalizes the exercise of a constitutional right is unconstitutional even though it reflects the social value judgment of the legislature. As the Supreme Court observed in *Shapiro, supra,* 394 U.S. at 631, 89 S.Ct. 1329:

> Thus, the purposes of deterring the immigration of indigents cannot serve as justification for the

> classification created by the one-year waiting period, since that purpose is constitutionally impermissible. If a law has "no other purpose . . . than to chill the assertion of constitutional rights by penalizing those who choose to exercise them, then it [is] patently unconstitutional." [Citation omitted.]

Perhaps the state may constitutionally choose not to pay for any medical services related to the condition of pregnancy. However, once the state decides to provide medical payments for those who choose one alternative medical treatment for pregnancy, i.e. childbirth; it cannot penalize those who choose the other constitutionally protected alternative medical treatment, i.e. abortion, because of an alleged fiscal interest. As Mr. Justice Brennan observed in his opinion for the Court in *Shapiro, supra,* 394 U.S. at 633, 89 S.Ct. at 1330:

> We recognize that a state has a valid interest in preserving the fiscal integrity of its programs. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes of its citizens. It could not, for example, reduce expenditures for education by barring indigent children from its schools. Similarly, in the cases before us, appellants must do more than show that denying welfare benefits to new residents saves money. The saving of welfare costs cannot justify an otherwise invidious classification.

All post-*Roe* case authority supports the proposition that statutes or administrative policies which restrict reimbursement for abortions are unconstitutional. *Doe v. Wohlgemuth, supra, aff'd on other grds., Doe v. Beal, supra; Doe v. Rose,* 499 F.2d 1112 (10th Cir. 1974); *Wulff v. Singleton,* 508 F.2d 1211 (8th Cir. 1975); and *Doe v. Rampton,* 366 F. Supp. 189 (1973).

For the reasons stated above, we find that Section 7 of the Abortion Control Act is in conflict with Title XIX of the Social Security Act. As to non-Title XIX funds, Section 7 violates the Equal Protection Clause of the Fourteenth Amendment and is inconsistent with the Supreme Court's decision in *Roe;* accordingly, we hold that Section 7 is unconstitutional.

IX. Regulations

Section 8 of the Act gives the Department of Health the authority to make rules and regulations with respect to the performance of abortions and the facilities in which abortions are performed. Plaintiffs contend that this provision intrudes upon the pregnant woman's fundamental right of privacy. The challenged section is as follows:

> Section 8. Regulations.—
>
> The Department of Health shall have power to make rules and regulations pursuant to this act, with respect to performance of abortions and with respect to facilities in which abortions are performed, so as to protect the health and safety of women having abortions and of premature infants aborted alive. Said rules and regulations shall include, but not be limited to procedures, staff, equipment, and laboratory testing requirements for all facilities offering abortion services.

Plaintiffs' assault on Section 8 is premature. This provision of Act 209 is merely an enabling provision granting the Department of Health the authority to make rules and regulations in the abortion area. At the present time, no regulations are before us which have been enacted by the Department of Health; thus, there are no regulations we can scrutinize to determine whether or not a constitutional deprivation has occurred. On the basis of the record before us, we will not assume that the regulations, if any, which may be enacted pursuant to the Act will be inconsistent with the Supreme Court's decisions in *Roe* and *Doe*[13]. Consequently, we find Section 8 not to be unconstitutional on its face.

X. *The Choice of Appropriate Relief*

In our consideration of the Abortion Control Act, we have severed provisions of the Act which we find to be unconstitutional and have denied plaintiff's request that we declare the whole Act unconstitutional as representing a legislative intent to control in an impermissible manner the fundamental right of a pregnant woman in consultation with her physician to decide to have an abortion. It is clear to this Court that the sections declared unconstitutional or inconsistent with a federal statute, if enforced against plaintiffs and the class they represent, would cause irreparable injury to plaintiffs. We recognize that this Court should enter only a declaratory judgment, and not the injunctive relief requested, if we are satisfied that

[13]E.g., in Roe, see discussion at 410 U.S. 163, 93 S.Ct. 732. And, see Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), cert. den., 95 S.Ct. 1438 (1975).

defendants will acquiesce in the decision holding the challenged provisions of the Act unconstitutional. *Poe v. Gerstein*, 417 U.S. 281, 94 S.Ct. 2247, 41 L.Ed. 2d 72 (1974); *Douglas v. Jeannette*, 319 U.S. 157, at 165, 63 S.Ct. 877, at 881, 87 L.Ed. 1324 (1943); *Dombrowski v. Pfister*, 380 U.S. 479, at 484-485, 85 S.Ct. 1116, at 1119-20, 14 L.Ed. 2d 22 (1965); *Zwickler v. Koota*, 389 U.S. 241, at 253-254, 88 S.Ct. 391, at 398, 19 L. Ed. 2d 444 (1967); *Roe v. Wade*, supra, 410 U.S. at 166-67, 93 S.Ct. at 733, 35 L.Ed. 2d 147 (1973).

In the instant case, counsel for defendant Fitzpatrick has stated in open court that defendant Fitzpatrick will abide by any declaratory judgment entered by this Court. With respect to the state defendants, we have a more difficult problem. We are aware of the fact that the Abortion Control Act was enacted by the Pennsylvania legislature over the veto of the Governor. The Governor's action in vetoing the bill as presented to him was based on the opinion of his then Attorney General that two sections of the Act were clearly unconstitutional on their face[14], and several other sections were of questionable constitutionality[15]. With this background we would ordinarily assume that the Governor would direct the Executive Departments to acquiesce in our declaration that certain sections of the Act are unconstitutional. However, in open court, but unfortunately off the record, counsel for the state defendants advised us that counsel could not give this Court any assurance that the state de-

[14]Namely, Sections 3(b)(i) and 3(b)(ii).

[15]Namely, the definition of "informed consent" found in Section 2, Sections 3(a), 6(f), 7, and 5(a).

fendants would abide by a declaratory judgment. Accordingly, the record does not support an assumption on our part that the state will acquiesce in a declaratory judgment decision and, therefore, we enter injunctive relief in favor of the plaintiffs and against all defendants as to the sections of the Act declared unconstitutional.

* * *

Informed Consent

For the reasons set forth in the separate opinion filed by Judge Adams and, as to that part dealing with informed consent, joined in by Judge Newcomer, the challenged sections of the Act relating to informed consent are declared to be constitutional. I have filed a separate dissenting view.

TO THE CLERK:

Please file the foregoing Opinion.

Clifford Scott Green
District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.
Plaintiff

Obstetrical Society of Philadelphia
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania
Intervenor Defendants

GREEN, *District Judge.*

Dissenting as to the decision on Informed Consent.

I dissent from the decision of the Court holding the informed consent provisions of the Abortion Control Act constitutional. I believe subsections (i) and (ii) of Section 2 and the informed consent criminal sanction provisions in Section 3 are unconstitutional because the provisions invade the privacy of the physician-patient relationship and violate the Fourteenth Amendment by regulating abortions more stringently than other medically indistinguishable procedures. The Act provides in relevant part:

Section 2. Definitions.—As used in this act:

. . . .

"Informed consent" means a written statement, voluntarily entered into by the person upon whom an abortion is to be performed, whereby she specifically consents thereto. Such consent shall be deemed to be an informed consent only if it affirmatively appears in the written statement signed by the person upon whom the abortion is to be performed that she has been advised (i) that there may be detrimental physical and psychological effects which are not forseeable, (ii) of possible alternatives to abortion, including childbirth and adoption, and (iii) of the medical procedures to be used. Such statement shall be signed by the physician or by a counselor authorized by him and shall also be made orally in readily understandable terms in so far as practicable.

. . . .

Section 3. Consent to Abortion; Limitations on Public Officials.—

(a) No abortion shall be performed upon any person in the absence of informed consent thereto by such person. Notwithstanding the foregoing provisions of this subsection, an abortion may be performed on any person if, in the medical judgment of a licensed physician, an abortion is immediately necessary to preserve the life of the woman and the woman is unable to give consent.

. . . .

(e) Whoever performs an abortion without consent as required in subsections (a) and (b) of this section shall be guilty of a misdemeanor of the first degree.

The opinion of Judge Adams states that the informed consent requirements of the Act merely codify Pennsylvania informed consent requirements, citing as authority *Dunham v. Wright*, 423 F.2d 940 (3d Cir. 1970). It is, of course, essential that the abortion procedure not be singled out for harsher regulation than other medical procedures. *Doe v. Bolton*, 410 U.S. 179, at 195-200, 93 S. Ct. 739, at 749-51, 35 L.Ed. 2d 201 (1973).

I agree with Judge Adams that *Dunham* correctly sets forth the law of Pennsylvania in regard to informed consent; however, the requirements of subsections (i) and (ii) of Section 2 far exceed the informed consent requirements of Pennsylvania law as set forth in *Dunham*. The fact that the requirements of the Abortion Control Act are not merely a codification of Pennsylvania law is readily apparent when one contrasts the Pennsylvania law as set forth in *Dunham* with the requirements of the Act. Significantly, if the absolute disclosure requirement of the Act had been applied to the facts of *Dunham*, an opposite holding would have been compelled.

The Third Circuit decided in *Dunham*, in an opinion by Judge Adams, that liability, as a matter of law, did not result from a failure of the surgeon to advise the patient that there was a percentage risk of death associated with the operation. In this regard, Judge Adams stated at 423 F.2d 946:

> Although this omission can be a serious one, in the setting of this case it does not require us to hold

as a matter of law that the defendants failed to discharge their burden of disclosure. In *Grunnagle,* the Court did not direct a verdict for the plaintiff although the record indicates that the defendant physician may have failed to inform the patient of a 10 to 15% risk that he would be worse after the operation; instead the Court said whether there was an informed consent was a question for the jury.

A reading of the Abortion Control Act clearly reveals that absolute liability, civil and criminal, is imposed for the failure to give to the patient the statutorily required information. When this section is compared with the holding in *Dunham,* I believe it is erroneous to say that the Act merely codifies the Pennsylvania law on informed consent; clearly, it adds new, absolute liability requirements applicable only to the performance of an abortion.

Contrast, also, the holding in *Dunham* that consent is informed if it may be inferred from the evidence that the patient was aware of an alternative treatment even though the physician did not advise the patient of the alternative medical treatment to surgery. It is clear that under Pennsylvania law the awareness of the patient is the crucial issue. However, under the Abortion Control Act, the failure to give the required information results in liability even though the patient is clearly aware of the information and of all the alternatives. Obviously, a patient who consults a physician knows that the alternative to abortion is childbirth; indeed, it is her knowledge of this alternative which impels her to seek an abortion in the first place. Nevertheless, under the Abortion Control Act a doctor commits a crime if he fails to advise her in accordance with the Act of the alternative of childbirth. Thus, patient awareness of the alternatives is a defense to all informed consent litigation except when it arises out of the performance of an abortion.

Furthermore, in *Dunham* the Court decided the law of Pennsylvania to be that "disclosure of alternative treatment means disclosure of alternatives for the particular patient and not a recital of medical case book theory." However, the Abortion Control Act requires the physician to recite legislative directives to his patient even if he does not believe them to be applicable to the particular patient. Such a requirement is not applicable to any other medical procedure.

In addition, the Act requires the doctor to advise all abortion patients of an alternative unconnected with medicine, i.e. adoption. I am aware of no other medical procedure where a physician is required, as a matter of informed consent, to advise a patient of a subject not included within his medical knowledge.

Finally, but most importantly, the physician is subject to criminal prosecution for failure to follow the provisions of the Act concerning informed consent. It is undisputed that only as to the performance of an abortion is failure to obtain an informed consent a crime in Pennsylvania.

Because of the aforesaid distinctions, applicable only when informed consent involves abortion, I believe the statutory provisions relating to informed consent, insofar as they require the information mandated in subsections (i) and (ii) are unconstitutional in that they single out for restriction the abortion procedure from all other similar surgical procedures and are unnecessary to protect

the state's important and legitimate interest in the health of the mother. The consent provisions of subsections (i) and (ii) are invalid because they legislatively mandate the elements that are to constitute an informed consent in the abortion field; yet the state has referred the Court to no other similar medical procedure with comparable consent requirements. Moreover, the state has referred the Court to no other medical procedure which has a criminal penalty for failure to obtain an informed consent. No rational or legally cognizable basis for these distinctions has been offered. The extra layer of regulation which these provisions impose in the abortion area is unreasonably burdensome of the patients' and physicians' rights under the Fourteenth Amendment of the Constitution. Cf., *Doe v. Bolton, supra,* 410 U.S. at 195-200, 93 S.Ct. at 749-51; *Word v. Poelker,* 495 F.2d 1349, at 1351-52 (8th Cir. 1974); *Hodgson v. Anderson,* 378 F. Supp. 1008, at 1018 (D. Minn. 1974); and *Friendship Medical Center, Ltd. v. Chicago Board of Health,* 505 F. 2d 1141, at 1152-53 (7th Cir. 1974).

Also, it is clear under *Roe v. Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed. 2d 147 (1973), that it is only at the end of the first trimester that the state's interest in maternal health becomes compelling and that the state may only regulate abortions after the first trimester if it can demonstrate that the regulation reasonably relates to the preservation and protection of maternal health. However, since the Act's informed consent requirements of subsections (i) and (ii) of Section 2 apply to the first trimester, the Act is for this reason alone inconsistent with the Supreme Court's decisions of *Roe* and *Doe. Doe, supra,* 410 U.S. at 195, 93 S.Ct. at 749.

Finally, the suggestion is made that a physician may legally satisfy subsections (i) and (ii) of Section 2, by first ritualistically following the requirements of the subsections and then negating the instructions by advising the patient he does not believe the required information is applicable to her condition. However, this process requires the physician to warn a patient of risks which he may not believe to exist and to inform the patient of alternatives, including adoption (clearly a non-medical alternative) which he may not believe to be available. Such a process is demeaning to the physician; confusing to the patient; and to some extent, deprives the patient of the honest opinion of her physician, which is essential for a meaningful consultation. No other medical procedure is so burdened.

I do not agree that the Act may be interpreted as merely requiring the giving of the requisite information and then permitting the recall of the instruction as inappropriate to the particular patient. The text of the Act does not support such an interpretation. To the extent that a physician, faced with criminal sanctions, is required to rely on such a speculative interpretation, the criminal provisions would appear to be unconstitutionally vague.

For the reasons set forth above, I would hold subsections (i) and (ii) of Section 2's definition of "informed consent", Section 3(a) of the Act to the extent that it incorporates the requirements of subsections (i) and (ii), and Section 3(e) of the Act to the extent that it applies to the requirements of Section 3(a) and subsections (i) and (ii), to be inconsistent with the Supreme

Court's decisions in *Roe* and *Doe*, and therefore unconstitutional.

TO THE CLERK:

Please file the foregoing Opinion.

Clifford Scott Green
District Judge

ADAMS, Circuit Judge, concurring and dissenting

The court is here obliged to card the tangled fibres of protected private rights and legitimate state interests in the troubling and unclear area of abortion regulation. Powerful responses are evoked by the subject of abortion and it is open to some doubt whether the courts are the institution best equipped to resolve the complex societal interests that exist in the abortion field. Nonetheless, the courts have been thrust into that role and it is incumbent on us to adjudicate the constitutional questions presented here.

The Supreme Court in *Roe*[1] and *Doe*[2] has decreed that the state may not prohibit the exercise of a woman's fundamental right to obtain an abortion—at least in the first two trimesters. A new generation of problems was spawned in the wake of those two decisions, respecting the degree to which authority to regulate abortions, or to affect them, is retained by the state. In defending the Abortion Control Act of 1974, Pennsylvania takes the position that broad power continues to be vested in the

[1]Roe v. Wade, 410 U.S. 113 (1973).
[2]Doe v. Bolton, 410 U.S. 179 (1973).

state to monitor abortion practices. By contrast, plaintiffs maintain that *Roe* and *Doe* and their implications leave the state a more limited authority to legislate than Pennsylvania has sought to exercise.

Roe and *Doe* now form part of the backdrop of our law, and no purpose would be served here by discussing the arguments that have been laid to rest by those decisions. In turning to deal with the fresh problems that have arisen, we must be mindful that the acts of a popularly chosen legislature are not to be lightly invalidated—surely, not on the basis of what a court or a particular judge deems wise or desirable from the standpoint of public policy. Furthermore, we should be keenly aware that *Roe* and *Doe* were innovative decisions, and the subtlety of the ultimate fabric of law affecting abortions is perhaps not yet discernible. I am, therefore, reluctant to leap ahead too quickly to interdict states from legislating respecting abortions when, in the accumulative informed judgment of the legislators, such enactments are necessary to serve legitimate interests of the populace.

It is with such admonitions in mind that I am unable to join in the views expressed by Judge Green in the following respects: I would not conclude that the informed consent provision defined in Section 2 and required by Section 3 is unconstitutional; nor would I find unconstitutional the requirement that consent for a minor's abortion must be obtained from a parent or person in loco parentis. And although in accord with the ultimate result reached by the majority on the question of viability, it seems fitting to express my somewhat differing views on that issue.

1. *Informed Consent*

Indisputably, informed consent would be necessary under Pennsylvania law before any medical procedure—including an abortion—may legally be performed.[3] To a considerable extent, the legislature has codified the informed consent requirement in section 3 of the Act and mandates that in the abortion field it be in writing.[4]

Plaintiffs assert that this requirement of written consent chills the right to choose to abort, and improperly interferes with the woman-physician relationship by interposing a state-ordained litany into the doctor's professional judgment regarding the information he or she finds it appropriate to tell a patient.[5]

No evidence has been adduced that persuades me that the information a doctor is requested to give under the statute would measurably chill the exercise of the abortion option. Therefore, the rational relationship test seems applicable,[6] and the burden lies with the plaintiffs to demonstrate the invalidity of this section.

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[3]Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970).

[4]Parenthetically, it may be noted that the directive that the consent be in writing operates, inter alia, for the protection of the doctor against subsequent claims that informed consent was absent.

[5]In Doe v. Bolton, supra p. 198-200, Justice Blackmun criticized the practice of the State of Georgia in requiring two physicians to agree before there may be an abortion, and states that such practice "has no rational connection with a patient's need, and unduly infringes on the physician's right to practice." However, no reference is made in the opinion to the question of informed consent as such.

[6]San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 28 (1973).

Employing that test, several reasonable bases appear to justify the required informed-consent provision. There are particular practical circumstances pertaining to the delivery of abortion services that might well generate substantial concerns on the part of the legislature. Accordingly, contrary to the assertions of the plaintiffs, separate attention addressed to abortion care does not appear per se unconstitutional under the Equal Protection Clause.[7] Rather, the separate treatment is suggested not by the choice of abortion, but by the realities of the system that provides abortions.

Abortions are frequently obtained in a specialized clinic or hospital department where a woman is removed from familiar medical surroundings. Most frequently the abortion is not done by a woman's regular doctor. The procedures, perhaps routine for those performing them, will probably be totally unlike any others theretofore undergone by the patient. In addition, as the record in this case indicates, the woman may well be experiencing considerable emotional anxiety.

Generally, the abortion decision is somewhat hurriedly arrived at and executed. It, in many cases, may be attended by a reticence that works to close off ordinary avenues of information to the patient either from friends or from family members.

The state under such circumstances might understandably wish to be certain that each woman be given the facts regarding her condition, her options, the abortion procedure to be performed and the possible future

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[7]Plaintiffs appear to acquiesce in this, for no attack is leveled on the requirement that the consent be written.

consequences of the choice she makes. Like the licensing of facilities, the regulations, and the record-keeping provisions, the informed consent requirement may well be an attempt by the state to monitor the quality of medical care received by women procuring abortions.

To the extent the requisite information respecting the alternatives to abortion are inappropriate in any particular case, the physician is not prohibited from so indicating to the patient *en passant*. A doctor may conclude that, in his or her professional judgment, it is unlikely that a patient will experience "detrimental physical and psychological effects which are not foreseeable."[8] In that event, while telling a patient that the law requires such advice, the Act does not foreclose the physician from putting this statement in perspective for a given patient by reassurances, or by comparing the risks of other options. Proper counseling, it would appear, could incorporate the information demanded by the state and tailor the comprehensive advice to the individual case.

Whether such a provision is prudent or imprudent or whether it is wise or unwise to provide a penalty in the nature of a misdemeanor when the physician does not supply the advice in question, is not a matter for the court to decide. Rather, it is within our province to say only whether the requisite consent is in no way related to legitimate state interests. This I am unable to do.

2. Consent by Parent or Person In Loco Parentis for Abortion on a Minor

Plaintiffs contend that the state by requiring adult consent to the performance of an abortion on an unemancipated pregnant female under the age of 18 forges an unconstitutional veto power over a young woman's fundamental right to abort. In many cases the effect of requiring consent, the argument continues, will be to deny the right totally, at the whim of a dissident parent.

[8]Abortion Control Act, Act No. 209, 35 P.S. §6601.

The provision is defended on the twofold basis that it serves a substantial state interest in the welfare of the minor regarding the serious decision to abort, and that it assures a parental role in the abortion choice of a child. Although I harbor some reservations regarding the latter justification for the requirement, under the statutory reading that appears reasonable to me I find the rationale adequate to sustain the restriction.

No explicit demarcation between adult and child is written in the Constitution, and it is by now clear that minors in many circumstances are vested with constitutional rights, though frequently they are not coterminus with the rights of adults. For example, Tinker v. Des Moines School District[9] established that students enjoy First Amendment rights of expression. In re Gault[10] held that fundamental due process rights appropriate to criminal proceedings must be applied in the quasi-criminal setting of a minor's delinquency hearing. And other Supreme Court decisions have clarified additional constitutional rights of minors.[11]

[9]393 U.S. 503, 514-515 (1969) (nondisruptive political protest). *See also* West Virginia v. Barnett, 319 U.S. 629 (1943) (salute to flag).

[10]387 U.S. 1 (1967).

[11]*See, e.g.*, Yoder v. Wisconsin, 406 U.S. 205 (1972) (religion); Ginsberg v. New York, 390 U.S. 629 (1968) (first amendment, obscenity); Prince v. Massachusetts, 321 U.S. 158 (1944) (religion); West Virginia v. Barnett, 319 U.S. 624 (1943) (due process).

There are at least two legitimate interests that a state may promote in enactments respecting minors. Legislation may be upheld either as an expression by the body politic for the protection of children or in order to secure claims of parental control over the care and up-bringing of children.[12]

Acting to further these ends, the state is empowered to legislate and, in some cases, to circumscribe the conduct of minors to a greater extent than it can legislate for adults.[13] Where the circumstances so require, the expression of protected rights asserted on behalf of minors may be curtailed or even prohibited.[14]

Beyond the freedom to determine whether and when to have a family, parents generally have broad power to make decisions affecting the schooling and religious upbringing of their offspring.[15] On occasion, the interests of the state in the minor and that of the individual parent have been at odds, and in such event the interests of both parties must then be weighed.[16]

There is no clash in the present case between the state and parent, or between the state and minor. Rather, the state seems to take a rather neutral attitude toward abortions for minors, neither prohibiting them altogether

[12]See *Ginsberg*, 390 U.S. at 639-40.

[13]Prince v. Massachusetts, 321 U.S. 158 (1944).

[14]*Prince*, supra note 3; *Ginsberg*, supra note 3.

[15]*Yoder*, supra note 3; Pierce v. Society of Sisters, 268 U.S. 510 (1925) (state could not prohibit private schools); Meyer v. Nebraska, 262 U.S. 390 (1923) (state could not prohibit the teaching of foreign languages in schools).

[16]*Compare Yoder*, supra note 3 with *Prince*, supra note 3.

nor emancipating the minor to make the grave abortion decision without the concurrence of a responsible adult.

Plaintiffs here, on behalf of the minors, assert a right to abort as freely as an adult. While there is no Supreme Court precedent governing the result when a minor independently claims fundamental rights consented to by neither parents nor the state, it does appear from the cases that, between them, the state and parent may exercise considerable control over a minor's activities. Faced with a challenge to a state statute prohibiting minors from selling publications on the streets, the Supreme Court in Prince v. Massachusetts[17] upheld the statute against claims bottomed on both the First Amendment freedom of religion and on parental due process. Under *Prince*, the state would appear to have the power to delimit the exercise by minors of protected freedoms if adequate foundation exists for the state regulation.

Similarly, *Tinker* upheld the notion that special circumstances pertaining to their situation might admit of a constricted exercise of First Amendment freedoms by minors in school.

The Supreme Court in Ginsberg v. New York[18] endorsed the concept that the scope and content of a protected right could be variable depending on whether the person asserting the right was a minor. The state statute sustained in *Ginsberg* prohibited the sale to minors of sexually explicit publications that were not obscene as to adults. The Court was careful to observe[19] that, while

[17]321 U.S. 158 (1944).

[18]390 U.S. 629 (1969).

[19]390 U.S. at 639.

sale to minors was prohibited, parents who so desired were not precluded from making such publications available to their children. *Ginsberg* seems somewhat parallel to the present situation, where the state provides that minors may not independently seek out access to sensitive matters (lascivious publications in *Ginsberg*, abortion in the case here), but with parental permission the state maintains no further independent interest in protecting the minor. There does appear to be some precedent therefore for enabling a state to condition a minor's access to a right—protected with respect to adults—upon an adult's consent.

The consent provision in the statute before us is open to a somewhat broader interpretation than that assumed by the plaintiffs and the majority. This is so since, in addition to consent by a parent or legal guardian, the statute provides for permission to be given by a person in loco parentis. The court has been directed to no evidence indicating that a restrictive interpretation of the phrase "person in loco parentis" was intended by the legislature. It would thus appear that consent would be acceptable from a responsible and caring adult who has a close relationship with the young pregnant woman.[20]

This more generous interpretation of the language "in loco parentis" would satisfy the interest of the legislature that the minor not be rushed into an abortion in

[20] "The principle is old and deeply imbedded in our jurisprudence that this Court will construe a statute in a manner that requires decision of serious constitutional questions only if the statutory language leaves no reasonable alternative." U.S. v. Gambling Devices, 346 U.S. 441 (1951), at p. 448. *See also* Driscoll v. Edison, 307 U.S. 104, 105 (1939).

which she was inadequately counseled, ignorant of the facts or unsupported psychologically. It would assure that some mature person with an interest in and relationship to the young pregnant woman would participate in her decision. Requiring consent affords a reasonable means to be certain that the adult undertake a degree of responsibility for the minor's resolution to abort.

The abortion decision should be made as intelligently as possible. Inevitably, the situation is accompanied by stress and urgency. The minor is, by the very fact of age, relatively inexperienced in making decisions of the type contemplated here. There is a legitimate interest on the part of the state in protecting the physical and emotional environments of the young woman. The state may permissibly conclude that it is in the best interest of the minor to assure that an adult has helped the young person arrive at an informed judgment.[21]

Accordingly, at least as it is interpreted in this opinion, it appears to me that the requirement that a parent or person in loco parentis consent to a minor's abortion is not unconstitutional.

3. *Viability*

I agree with the majority that the term viability is not sufficiently susceptible of objective and predictable definition for criminal penalties to turn on what is necessarily an after-the-fact extrapolation whether a fetus was viable at the time of an abortion.

Nevertheless, the dilemma suggested by the result we reach today warrants some attention. Indisputably, the

[21] 390 U.S. at 639.

state has a profound interest in preserving human life, including the life of a viable but unborn fetus.[22] It therefore would seem to lie within the legitimate exercise of the police power for the state to prohibit the destruction of such viable fetal life.

Difficulty arises in formulating a criminal sanction respecting late-term abortion because, based on the record in this case, the point at which the fetus matures to viability is not universally agreed upon as a matter of medical definition. The legal definition of the instant at which life occurs to a fetus, as a standard to guide professional conduct, appears vague because it derives from a medical interpretation that lacks the specificity required for criminal sanctions.

As observed by the majority, there is a consensus regarding the applicable guidelines for determining viability—in particular the length of time since the last menses and the size of the fetus as determined by abdominal measurement of the mother. However, three principal factors render the viability definition uncertain. First, the diagnosis is not foolproof but is an estimate of fetal age. Second, whether any given fetus would survive a premature delivery cannot be ascertained in advance. Third, the evidence revealed that medical practitioners accept different statistical survival rates as determinative of viability. In the view of some of the physicians who testified, if a fetus of a certain gestatioral age had survived in the annals of medical history, such period set a base age for viability. For other doctors, unless a fetus reached a size where a 10% likelihood of survival could

[22] *Roe*, supra note 1; *Doe*, supra note 2.

be expected, the point of viability, in their judgment, had not been achieved.

In the situation covered by the statute, until the line demarcating criminality is crossed, the conduct involved is constitutionally protected. The statute is assailed because the conduct in very many situations when performed cannot readily be identified as criminal or non-criminal.

Grayned v. City of Rockford[23] addressed a statute regulating picketing, allegedly defective on vagueness grounds. There the Supreme Court described the vice of vagueness as follows:

> . . . Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abut[s] upon sensitive areas of basic First Amendment freedoms," it "operates to inhibit the exercise of [those] freedoms." Uncertain meanings inevitably lead citizens to " 'steer far wider of the unlawful zone' . . .

[23] 408 U.S. 104 (1972).

than if the boundaries of the forbidden areas were clearly marked."[24]

Until viability, a woman has a fundamental right to abort but, once having traversed the viability line, the state has a compelling interest in restricting abortion. Normal caution to avert potentially criminal activity will produce the effect of chilling the exercise of the protected right. For this reason a proscriptive statute must be narrowly drawn or else it will, as a practical matter, invade the protected right.[25]

The Pennsylvania Abortion Statute is unlike others whose broad language has been saved by repeated applications that have narrowed and supplied meaning by interpretation.[26] The problem here is not that the legal definition of the criminal behavior is broad, but that it applies a standard, viability, malleable at the time of the conduct and respecting which experts do not agree.

It is true that the Supreme Court has held that the critical mark in time for purposes of forbidding abortion is viability. Because the definition of the threshold of viability is riddled with the uncertainties cited above, however, that concept is not an adequate guide for phy-

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[24]408 U.S. at 108-09 (footnotes omitted), quoting Baggett v. Bullitt, 377 U.S. 360, 372 (1964); Cramp v. Board of Public Instruction, 368 U.S. 278, 287 (1961).

The seminal article on vagueness is Amsterdam, "The Void for Vagueness Doctrine in the Supreme Court," 109 U. Pa. L. Rev. 67 (1960).

[25]*See for example* N.A.A.C.P. v. Button, 371 U.S. 415, 438 (1963).

[26]*See* CSC v. National Ass'n. of Letter Carriers, 413 U.S. 548 (1973); Parker v. Levy, 417 U.S. 1974).

sicians who would frequently be free to exercise their best professional judgment only at the risk of criminal penalties. To be valid, a statute should provide more objective standards, giving firmer indications of the limits of protected conduct.

4. Subsidization of Abortions

Before enacting the Pennsylvania Abortion Control Act, the Pennsylvania Welfare Department promulgated a regulation to the effect that only medically indicated abortions were eligible for state reimbursement under the Medical Assistance Program. A suit challenging the constitutionality of the regulation was just recently decided by the Third Circuit, in banc.[27] To the extent that the issues are identical,[28] I consider myself bound here by the law of this Circuit. My own views, which differ from those of the majority, are noted separately in Doe v. Beale, and it would serve no additional purpose to elaborate them here.

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[27]Doe v. Beale, C.A. Nos. 74-1726, 74-1727, decided July 21, 1975.

[28]As to the section of the Act dealing with financing of abortions for medically indigent women by local communities, there is no mention of such possibility in the record here, and I am aware of no such action or contemplated action—at least in Pennsylvania. Accordingly, I do not consider this issue a justiciable one in the setting of this case, and certainly it is not one that is ripe for constitutional adjudication. *See,* for example, Justice Rutledge's statement in Rescue Army v. Municipal Court, 331 U.S. 549 (1947), and Justice Frankfurter's concurring opinion in Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 156 (1951).

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al

v.

F. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County, et al

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NEWCOMER, J., Concurring

While the majority opinion expresses my views on most of the issues involved in this case, I feel compelled to set forth separately my views on the issues of parental and spousal consent.

The opinion of the majority, without affirming or denying the existence of any parental rights in the supervision and guidance of unemancipated minor children, finds that the act's parental consent provisions are not narrowly enough drawn to withstand constitutional challenge. While I agree with this conclusion, I am of the view that parents indeed have such rights and that the state may, within certain limitations, legislate to protect these rights. The Supreme Court has not precluded the states from legislating for that purpose and it is generally

recognized that the state may abridge the constitutional rights of minors in situations where it may not abridge those of adults. See, e.g., *Ginsburg v. New York,* 390 U.S. 629 (1968). The Supreme Court has recognized the fundamental right of the parents to choose their children's school, *Pierce v. Society of Sisters,* 268 U.S. 510 (1925), to choose what their children will learn, *Meyer v. Nebraska,* 262 U.S. 390 (1923), and even to decide whether their children will attend school, *Yoder v. Wisconsin,* 406 U.S. 205 (1972). While I am not aware of any case involving a collision between the minor's rights and the parent's right to supervise the minor's upbringing, I believe that the two lines of cases discussed above permit the state to intervene to enforce parental rights.

The state's authority to preserve the right of parents to supervise their children's upbringing rests upon a larger concern: the preservation of the family as the basic unit of our society. This larger interest has been held by the Supreme Court to justify legislation which gives zoning preference to families over non-kinship groups. *Village of Belle Terre v. Boraas,* 416, U.S. 1 (1974). This broader concern includes the relationship between spouses as well as the relationship between parents and children. The participation of one spouse in the important decisions of the other is equally as important to the health of the family as is the participation of the parents in the important decisions of their children.

I believe that the state may take steps to insure such participation as part of its legitimate concern with protecting and preserving the family. Such a concern was undoubtedly in the minds of the Pennsylvania legislators when they enacted the parental and spousal consent pro-

visions of the Abortion Control Act. However, the means which they chose to insure parental and spousal participation—an unqualified veto, without the right of appeal—infringes the constitutional rights of privacy possessed by the family's individual members and is therefore unconstitutional.

That we are today invalidating the means chosen by the legislature should not be interpreted as a refutation of the legitimacy of its goals. I believe that the state could reasonably and constitutionally require a doctor who plans to perform an abortion on a married woman, or an unmarried minor, to notify and inform the husband, or at least one parent, of his plans. In this way the affected family member would be given the opportunity to fulfill his or her role as a source of guidance for, or as the partner of, the pregnant woman. But a statute which gives a parent or a husband an unappealable veto over this one medical decision far exceeds what is necessary to achieve the state's or the other family members' interest, and transgresses upon that private area secured to the woman, whether married or unmarried, adult or minor, by *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973).

Moreover, the Act's parental consent provision suffers from an additional constitutional defect. We note that another Pennsylvania statute, enacted prior to the Abortion Control Act, grants to pregnant minors the right to consent to medical, dental, and health services, and establishes that such consent is effective without the consent of anyone else. 45 Purdon's Statutes §10101. (February 13, 1970). While this law was repealed insofar as it relates to abortion procedures by the Abortion Control Act, this signaling out of abortion appears inconsistent with the Supreme Court's opinions in *Roe* and *Doe*, cited supra. If the Pennsylvania legislature had not granted this general unqualified right to consent to pregnant minors, or if it repealed it *entoto*, the abortion decision would merely be one, rather than the only one, of many health areas in which the parents would have the right to supervise their children.

While I share the philosophy and rationale reflected by most of the views expressed in the separate concurring and dissenting opinion of my respected colleague Judge Adams, I am unable to agree that the parental consent provision can be saved by interpreting the provision's "in loco parentis" language to embrace any "responsible and caring adult who has a close relationship with the young pregnant woman." (Adams, C.J. dissent, at p. 10). While this interpretation is reasonable in the case of orphans or those minors whose parents are mentally incompetent, unknown, or unavailable, it would not appear to be faithful to the spirit of this Act to allow a third-party to consent where the parents are able but unwilling to do so. The Courts, which under the existing provision are not permitted to adjudicate a conflict between parents and minors over the abortion decision, would have to adjudicate conflicts arising from contradictory claims by the natural parents and the person acting "in loco parentis." Moreover, this adjudication would take place not prior to the abortion, but in a criminal proceeding against the physician following the abortion. This procedure would inevitably result in restricting the consent provision to the natural parents, even if this was not the legislature's intent.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.
Plaintiffs

Obstetrical Society of Philadelphia
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania
Intervenor Defendants

ORDER

AND NOW, this 4th day of September, 1975, for the reasons set forth in the Opinion accompanying this Order, IT IS ORDERED that:

(1) State defendants' motions to dismiss Planned Parenthood Association of Southeastern Pennsylvania, Concern for Health Options: Information, Care and Education, Inc., and Clergy Consultation Service of Northeastern Pennsylvania are GRANTED for the reasons set forth in this Court's Opinion.

State defendants' motion to dismiss the Obstetrical Society of Philadelphia is DENIED;

(2) The sections of the Abortion Control Act are declared to be severable and plaintiffs' request to enjoin the Act in its entirety is DENIED;

(3) Section 2's definition of "informed consent", Section 3(a), Section 5(c), Section 6(a), Section 6(c), and Section 8 of the Abortion Control Act are constitutional;

(4) Section 6(d) of the Act is constitutional to the extent that it requires information concerning: "the name, address and age of the woman upon whom the abortion was performed; the date on which the abortion was performed; the date upon which the determination of pregnancy as required by this section was made; . . . ; the approximate age, in months, of the fetus; . . . Affixed to such statement shall be a copy of each of the documents showing consent to abortion as required by section 3 of this act. All information and documents required by this subsection shall be treated with confidentiality customarily accorded to medical records.";

(5) Section 6(d) of the Act is unconstitutional to the extent that it requires information concerning; "the name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; . . . ; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother.";

(6) Section 2's definition of "viable", Section 3 (b) (i), Section 3 (b) (ii), Section 5 (a), Section 6 (b), Section 6 (f) are unconstitutional; and Section 7 of the Abortion Control Act is inconsistent with Title XIX of the Social Security Act and is unconstitutional; and,

(7) The defendants, their agents, their employees, successors in interest, and all others acting in concert with them, are enjoined from the enforcement of the sections of the Act that have been held by this Court to be unconstitutional.

BY THE COURT:
Arlin M. Adams
Circuit Judge
Clarence C. Newcomer
District Judge
Clifford Scott Green
District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.,
Plaintiffs

and

Obstetrical Society of Philadelphia,
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr. and Frank S. Beal,
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania,
Intervenor Defendants.

MEMORANDUM

Before ADAMS, *Circuit Judge* and NEWCOMER and GREEN, *District Judges.*

(Filed September 16, 1977)

GREEN, *District Judge.*

On September 4, 1975, we filed opinions and an order adjudicating constitutional challenges to specific sections of the Pennsylvania Abortion Control Act (Act)[1];

[1]Act No. 209 of 1974, 35 P.S. §7701, *et seq.*

the parties appealed. The Supreme Court of the United States affirmed the judgment of this Court in regard to plaintiffs' appeal; however, on consideration of defendants' appeal the Supreme Court vacated the judgment entered and remanded to this Court "for further consideration in light of *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. —— (1976); *Singleton v. Wulff*, 428 U.S. —— (1976) and *Virginia Citizens Consumer Council*, 425 U.S. —— (1976)."

We have reconsidered the challenged sections in light of the aforesaid decisions of the Supreme Court and enter an order in compliance therewith. Also, the order entered conforms with the stipulation of the parties, except as it relates to section 5(a) of the Act[2]. Since the parties are unable to agree to the proper resolution of the challenge to section 5(a), they have submitted the issue to the Court, on briefs, for decision.

After reconsideration of section 5(a) in light of the most recent Supreme Court decisions, we adhere to our

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[2]Section 5(a) provides:

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

original view and decision that section 5(a) is unconstitutional[3].

Counsel for the parties have not stipulated as to section 7 of the "Act"[4], electing to have the Court decide the issue after consideration of the decisions of the U.S. Supreme Court in *Beal v. Doe*, —— U.S. ——, 97 S.Ct. 2366, —— L.Ed. 2d —— (1977) and *Maher v. Roe*, —— U.S. ——, 97 S.Ct. 2376, —— L.Ed. 2d —— (1977). We declare section 7 does not violate Title XIX of the Social Security Act, *Beal v. Doe, supra;* nor does section 7 violate the Equal Protection Clause of the Fourteenth Amendment, *Maher v. Roe, supra.*

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[3]Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (1975).

[4]Section 7 provides:

Since it is the public policy of the Commonwealth not to use public funds to pay for unneeded and unnecessary abortions, no abortion shall be subsidized by any State or local governmental agency in the absence of a certificate of a physician, filed with such body, stating that such abortion is necessary in order to preserve the life or health of the mother.

Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations, made by the Commonwealth or a local governmental agency to hospitals for their maintenance and operation, or, for reimbursement to hospitals for services performed. 1974, Sept. 10, P.L. 639, No. 209, §7, effective in 30 days.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.,
Plaintiffs

and

Obstetrical Society of Philadelphia,
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr. and Frank S. Beal,
Defendants,

and

Robert P. Kane and The Commonwealth of Pennsylvania,
Intervenor Defendants.

ORDER

AND NOW, to wit this 16th day of September, 1977, upon consideration of the pleadings, evidence, memoranda filed and in consideration of the stipulation and proposed order counsel filed in this action it is hereby ordered, adjudged and decreed:

I. The following sections of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P.S. §6601,

et seq. are constitutional and enforceable as set forth below:

Section 2, definition of Viable.

Section 5 (d) insofar as it relates to Section 5 (b)

Section 6 (b)

Section 6 (d) insofar as it relates to the following information: the name, address, and age of a woman upon whom the abortion was performed, the date on which the abortion was performed, the date upon which determination of pregnancy was made; the approximate age of the fetus and, if applicable, a full statement of the facts upon which the person performing the abortion relied on establishing that the abortion was necessary for the life and health of the mother and insofar as it requires patients consent to be affixed to the facility statement.

Section 7. Also, we declare that Section 7 does not violate Title XIX of the Social Security Act.

II. The following sections of the Pennsylvania Abortion Control Act are unconstitutional and therefore enjoined:

Section 3 (b) (i).

Section 3 (b) (ii).

The first sentence of section 3 (e) as it relates to section 3 (b).

Section 5 (a).

Section 5 (d) insofar as it relates to Section 5 (a).

Order Dated Sept. 16, 1977

Section 6(d) insofar as it requires records regarding information related to the spouse or parent of the woman upon whom the abortion was performed, and insofar as it requires the spousal and parental consents to be affixed to the facility statement.

Section 6(f) except insofar as it prohibits physicians from advertising and the plaintiffs' action on this aspect of Section 6(f) is dismissed without prejudice to the members of the class as certified by the District Court. Plaintiffs withdraw any challenge to the prohibition of physicians advertising.

BY THE COURT:

Arlin M. Adams
Circuit Judge

Clarence C. Newcomer
District Judge

Clifford Scott Green
District Judge

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare
of the Commonwealth of Pennsylvania,
ROBERT P. KANE, Attorney General
of the Commonwealth of Pennsylvania,
THE COMMONWEALTH OF PENNSYLVANIA,
and F. EMMETT FITZPATRICK,
Appellants

vs.

JOHN FRANKLIN, M.D., and
OBSTETRICAL SOCIETY OF PHILADELPHIA,
Appellees

On Appeal
From the United States District Court
For the Eastern District of Pennsylvania

APPELLEES' MOTION TO DISMISS OR AFFIRM

Roland Morris
Counsel for Appellees

1600 Land Title Building
Philadelphia, PA 19110
215/854-6376

APPELLEES'
MOTION TO DISMISS OR AFFIRM

I

COUNTER-STATEMENT
OF QUESTION PRESENTED

Whether the lower court erred in declaring unconstitutional the mandate of Section 5(a) of the Pennsylvania Abortion Control Act, P.L. 209 of 1974, 35 Pa. Purdon's Statutes (P.S. 6605(a) [text set forth at pp. 7-8 of Appellants' Jurisdictional Statement], enforced by Section 5(d) of the Act, 35 P.S. 6605(d).

II

MOTION

Appellees respectfully move that the Supreme Court of the United States summarily affirm the holding of the three-

judge District Court, respectfully suggesting that:

a) The appeal does not present a substantial federal question; and,

b) Under the United States Constitution and existing precedent, the decision of the three-judge District Court was appropriate and indeed required.

In support of this Motion, it is respectfully submitted that Section 5(a) of the Pennsylvania Abortion Control Act unconstitutionally attempts to carve out a period of time during which a fetus "may be viable" and imposes requirements relating to the decision to abort during this period which are flatly inconsistent with the Constitution and holding of the Supreme Court of the United States in Roe v. Wade, 410 U.S. 113 (1973).

In invalidating Section 5(a) of the Act, the three-judge District Court properly reasoned that it tends to carve out a period of "potential viability" which, according to defendants' own witness, would occur at 20 to 26 weeks, in which the State seeks to regulate abortion in the interest of the fetus. The Section is in conflict with the Court's decision in Roe v. Wade, supra, which provides that before viability (which occurs at 24 to 27 weeks' gestation) the State may only regulate abortion in the interest of maternal health. The subsequent three-judge Court in the Middle District of Pennsylvania, Doe v. Zimmerman, 405 F.Supp. 534 (1975), also concluded that Section 5(a) of the Act was unconstitutional.

Since the purpose of an abortion is invariably to obviate rather than facilitate a live birth, the effect of Section 5(a) would be to put a physician in jeopardy of criminal sanctions[1/] where an abortion is performed between the 20th and 26th week of gestation. It would necessarily and by definition impose a chilling effect upon the constitutionally protected right of the woman, in consultation with her physician, to terminate a pregnancy during the latter portion of the second trimester.

For example and pertinently, the record in this case demonstrated that limiting abortion before the end of the second trimester of pregnancy would tend

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1/ Section 5(d) provides for the enforcement of 5(a) through criminal sanctions.

to undermine the opportunity of families with certain genetic characteristics to conceive and bear their own biological children and in some cases would lead to the abortion of normal and wanted children.

Dr. Hope Punnett, an expert on genetic testing and counseling, whose testimony was unrefuted in relevant part, testified that where couples have been identified as carriers of certain genetic disorders, a test can be performed during pregnancy to determine whether the fetus is affected with the genetic abnormality. For many of these conditions, the test requires culturing cells taken from the amniotic fluid. The test cannot be initiated until 16 weeks' gestation, and if the culture is successful, it takes two

to six weeks to get results (R. 93) 2/. If the cells in the initial culture do not grow, a second tap may be required, which would involve a further delay of one to ten days (R. 94). Consequently, positive results cannot be obtained until 18 to 20 weeks' gestation, and often later (R. 96).

Genetic abnormalities which can be diagnosed only through this method include Down's Syndrome (Mongolism) and Tay-Sachs. Tay-Sachs is a condition in which children are born apparently normal infants, and begin deteriorating when they are six months old. By age three, they have lost all function and require custodial care until they die at age 7 or 8 (R. 89-90).

2/ All references to the Record in the present Motion are to the testimony of Dr. Hope Punnett in the transcript of January 14, 1974 (sic. 1975).

Unlike most genetic conditions, where affected families are identified only after one child is born with the disease, Tay-Sachs carriers may be identified by a simple blood test (R. 91). Approximately one in every 15 Jews of Eastern European origin are carriers of this disorder, and there is a screening program in Philadelphia which seeks to test all members of this population for the trait (R. 98). Where both members of a couple are Tay-Sachs carriers, there is a 25% chance that a pregnancy will involve Tay-Sachs (R. 91). Where a couple are both identified as carriers of Tay-Sachs, the options presented through counseling are: 1) proceeding with conception in spite of the risk, 2) preventing conception entirely, 3) artificial insemination with a donor who is not a carrier, and 4) conception with prenatal

diagnosis and the possibility of aborting an affected fetus — the only option which would enable them to have their own biological children without risk (R. 91-92).

When asked what would happen if there were a cutoff of 20 weeks' gestation for abortion, Dr. Punnett demonstrated that it would severely undermine a genetic counseling program, because it is not possible to be assured of a final result from prenatal diagnosis within that period, and "one cannot do genetic counseling if you cannot follow it to a logical conclusion (R. 96). Where the test was not conclusive before 20 weeks, the family would be deprived of the benefits of the test results which could be obtained and forced to a choice of carrying through the pregnancy in spite of the risk, or aborting what may turn out to have been a normal and wanted child (R. 96).

III

CONCLUSION

For these reasons, both legal precedent and policy require that the decision of the District Court invalidating Section 5(a) of the Pennsylvania Abortion Control Act be affirmed or that this appeal be dismissed.

Respectfully submitted,

Roland Morris, Esquire
Counsel for Appellees

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Philadelphia, PA 19110

215/854-6376

2/15/78

CERTIFICATE OF SERVICE

I, the undersigned attorney for Appellees, and a member of the bar of the United States Supreme Court, do hereby certify that pursuant to the Supreme Court Rule No. 33, I have caused to be served true and correct copies of the foregoing Motion to Dismiss or Affirm upon each party required to be so served, by depositing said copy in the United States Postal Service mail box, with first-class postage prepaid and affixed, addressed as follows:

J. Jerome Mansmann, Esquire
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare
of the Commonwealth of Pennsylvania
Et Al.

Appellants

vs.

JOHN FRANKLIN, M.D., Et Al.

Appellees

On Appeal From the United States District Court
For the Eastern District of Pennsylvania

MOTION FOR APPOINTMENT OF ALAN ERNEST AS GUARDIAN AD LITEM FOR UNBORN CHILDREN

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The Court is moved to appoint Alan Ernest as Guardian ad litem for unborn children in Pennsylvania. There is no counsel to represent the unborn children, yet it is there right to live that is at issue. Furthermore, the Guardian will defend the constitutional right to life of unborn children, as outlined below, which neither of the parties will do.

INTEREST OF GUARDIAN

Alan Ernest is a lawyer in the District of Columbia. His interest is to protect the constitutional rights of unborn children.

QUESTION PRESENTED BY GUARDIAN

For the eleventh time, the Supreme Court is petitioned to overrule its abortion decision, Roe v. Wade, 410 US 113(1973), on the grounds that it is based on false evidence and millions of lives have been unconstitutionally exterminated. See THE CASE AGAINST THE SUPREME COURT, at 5-6, infra.

OUTLINE OF CONSTITUTIONAL ISSUES PRESENTED BY THE GUARDIAN

The Guardian's case was well presented in the ninth petition to overrule Roe v Wade(David Gaetano v Earl Silbert, United States Attorney for the District of Columbia, No. 77-1406, Cert. denied May 1, 1978):

"An EXHIBIT A established that Roe v Wade was based on false evidence by showing that(See EXHIBIT A, page 1, "Summary of Evidence"):

"1. even the Supreme Court admitted in Roe v Wade that if the unborn were a ' "person" within the language and meaning of the Fourteenth Amendment' then the case for abortion on demand 'of course, collapses, for the fetus' right to life is then guaranteed specifically by the Amendment,' and

"2. the express, universal terms of the Fourteenth Amendment ('nor shall any State deprive <u>any person</u> of life . . . without due process of law') (emphasis added) on their face, protect the lives of the unborn, as everyonc else, and

"3. the holdings of Chief Justice John Marshall (that can be traced through the Constitution, The Federalist Papers, and the Federal Convention of 1787) show that the Supreme Court has no lawful power to construe exceptions to express, universal terms (such as 'any person') unless the Court can

prove the exception to the express, universal terms beyond a reasonable doubt, and show that 'had this particular case been suggested' to the framers, the 'language would have been so varied, as to exclude it,' and

"4. the Supreme Court presented false evidence to support its conclusion in Roe v Wade that 'the word "person," as used in the Fourteenth Amendment, does not include the unborn' and but for the false evidence, there is not even a credible foundation, much less a compelling one, for denying the protection of the express, universal terms 'any person' to the lives of the unborn, and

"5. the truthful history corroborates that the express, universal terms 'any person' include the unborn, as they do all categories of persons, and more certainly than many groups. The Supreme Court included corporations and aliens as a 'person' within the language and meaning of the Fourteenth Amendment merely on the strength of the express, universal terms 'any person,' without any independent corroborating evidence whatsoever. (The unborn being the only persons ever excluded from the terms 'any person')

"In short, EXHIBIT A shows that the Supreme Court exactly violated the very letter of the Constitution, as well as its spirit, and condemned millions of victims to death whom the Constitution endeavours to preserve."

. . . .

"Roe v Wade asserts a second method . . . for the government to condemn persons to death:

"The First, set out in the Constitution, is by conviction by an impartial jury for violation of express laws enacted by the people and applicable to all in the state; with right to representation by counsel; with right to be acquitted unless found guilty beyond a reasonable doubt; with provision to stop execution if new evidence is discovered.

"The Second, set out in Roe v Wade, is for a Tribunal holding office for life(without assistance of counsel to defend the victims)to rule the victims out of the human race as inferiors, in violation of the very letter and spirit of the Constitution, falsifying evidence to make the homicides appear legal, and year after year to repeatedly deny applications showing the exterminations to be illegal.

. . . .

"(I)n 1975, the Supreme Court of Germany held that the clause in the German Constitution, "Everybody has the right to life," also "includes unborn human beings," that "Abortion is an act of homicide," and the state has a "duty" under the Constitution " to protect unborn life." See translation, 63 California Law Review at 1342, 1348-49. . . . (I)t is of paramount importance to examine how it is possible for the high courts of two major nations, construing constitutional phrases that are in substance identical, to reach diametrically opposing conclusions about the legality of millions of premeditated homicides. That examination, presented in EXHIBIT A, surely permits reasonable people to conclude beyond a reasonable doubt that the Supreme Court closed its eyes on the Constitution and condemned to death those victims whom the Constitution endeavours to preserve; and there appears to be no defense that will not amount to a claim that the Supreme Court is above the law,- as Hitler was to Germany, so the Court is to America.

"If it be true, as Chief Justice Marshall once held(see Marbury v Madison, 1 Cranch 137, 163, 176, 178) that "government of laws, and not of men," founded in a "written constitution" deriving its just power from the "supreme" "authority" of "the people" is "the greatest improvement on political institutions," then the overthrow of that government of laws by lawless federal judges may be the most heinous crime in the history of government.

. . . .

"APPENDIX

"THE CASE AGAINST THE SUPREME COURT

"The evidence appears to support the charge that some Justices of the U.S. Supreme Court have violated federal criminal statutes, such as:

"18 USC 242, Deprivation of rights under color of law,- It is a crime for government officials, acting under pretense of law, to willfully deprive persons of their rights secured by the U.S. Constitution. The documentation in EXHIBIT A, at the very least, permits reasonable people to conclude beyond a reasonable doubt that the unborn are persons whose lives are protected by the U.S. Constitution. The evidence that Justices specifically authorized killings throughout the United States, by a willfully false construction of the Constitution, would certainly permit a jury to conclude beyond a reasonable doubt that Justices, acting under pretense of law, had deprived millions of unborn persons of their right to life protected by the U.S. Constitution.

"22 D.C. Code 201, D.C. abortion statute,- The felony abortion statute only permits abortions in the District of Columbia to preserve the mother's life or health. The evidence that Justices specifically authorized non-therapeutic abortions in violation of the positive criminal statute, by a willfully false construction of the Constitution, would surely permit a jury to find beyond a reasonable doubt that Justices had aided and abetted those killings.

"22 D.C. Code 105 a, Conspiracy,- When Roe v Wade was decided, non-therapeutic abortions were illegal, not just in the District of Columbia, but generally throughout the United States. The evidence that Justices specifically authorized non-therapeutic abortions in violation of the States' positive criminal statutes, by a willfully false construction of the Constitution, would appear to permit a jury to find beyond a reasonable doubt that Justices conspired to effect those killings.

"18 USC 1503, Obstruction of justice,- It is a

crime to endeavor to obstruct or impede the due enforcement of the law of the land, even by conduct that is otherwise legal, if the motive is corrupt or dishonest. The evidence that the Supreme Court has been petitioned year after year to overrule Roe v Wade on the grounds that it is based on false evidence and millions of lives have been illegally exterminated, and year after year the Supreme Court summarily refused to even listen, would appear sufficient to permit a jury to conclude beyond a reasonable doubt that Justices had dishonestly endeavored to obstruct or impede the due enforcement of the law of the land.

"18 USC 1001, False statements,- The evidence that some Justices, within their official jurisdiction, made or adopted false statements in Roe v Wade, and repeated petitions indicated the false statements to be willful and knowing, might be sufficient to permit a jury to conclude beyond a reasonable doubt that some Justices had made false statements within 18 USC 1001.

"18 USC 371, Conspiracy,- It is not only a crime to conspire to commit any criminal offense, but also to conspire to defraud the United States by misrepresentation or the overreaching of those charged with the carrying out of the governmental intention. The evidence already mentioned would appear sufficient to permit a jury to find beyond a reasonable doubt that Justices had not only conspired to commit the above mentioned crimes, but also to defraud the United States.

"18 USC 1621, Perjury,- An oath of office to uphold the Constitution would probably not, under ordinary circumstances, support a charge of perjury. However, Chief Justice John Marshall held that for "judges" to "swear" to discharge their duties "agreeably to the constitution" and then "close their eyes on the constitution" and "condemn to death those victims whom the constitution endeavours to preserve" is worse than "solemn mockery," it is a "crime." Marbury v Madison, 1 Cranch at 179-180.

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1977

DAVID GAETANO and ALAN ERNEST, Next Friend of Unborn Child Roe and All Others Similarly Situated, PETITIONERS	)	
vs.	)	No. 77-1406
EARL J. SILBERT, United States Attorney for the District of Columbia, RESPONDENT	)	

WAIVER

The Government hereby waives its right to file a response to the petition in this case, unless requested to do so by the Court.

Wade H. McCree, JR.
Solicitor General

APRIL 6, 1978

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D.C. 20543

May 1, 1978

Alan Edward Ernest, Esq.
5713 Harwich Ct.
#232
Alexandria, VA 22311

RE: David Gaetano, et al.
v. Earl J. Silbert, etc.
No. 77-1406

Dear Sir:

The Court today denied the petition for a writ of certiorari in the above-entitled case.

Very truly yours,
MICHAEL RODAK, JR., Clerk
By
/s/ Edward Faircloth
Assistant Clerk

And silence, in the face of a charge, can be taken as an admission that the charge is true. See McCormick on Evidence 651-54(2d ed 1972).

CONCLUSION

The Court is moved to appoint Alan Ernest as a guardian ad litem so that the unborn will have a lawyer to defend their constitutional rights.

In the alternative, the Court is moved to let Alan Ernest intervene as a next friend of the unborn children in Pennsylvania.

It can not be pretended that it is any longer the government of the United States,-any government of Constitution and laws,- if these unborn children are to be denied representation of counsel to defend their constitutional right to life.

Alan Ernest
5713 Harwich Ct #232
Alexandria, Va 22311

Counsel

IN THE

Supreme Court of the United States

October Term, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,
Appellants

vs.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA
Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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TABLE OF CONTENTS

	Page
CITATION TO OPINION BELOW	1
JURISDICTION	1
CONSTITUTIONAL PROVISIONS INVOLVED	1
STATUTORY PROVISIONS INVOLVED	2
QUESTIONS PRESENTED	3
STATEMENT OF THE CASE	
A. Procedural History	4
B. Evidence at Trial Relating to Section 5(a)	6
SUMMARY OF ARGUMENT	13
ARGUMENT	14
INTRODUCTION	14
I. THE LOWER COURT ERRED IN DECLARING UNCONSTITUTIONAL THE MANDATE OF SECTION 5(a) WHICH REQUIRES THE PHYSICIAN WHO PERFORMS AN ABORTION FROM VIABILITY ONWARD TO PROTECT THE LIFE OF A FETUS	16
(a) The legislature has the power to regulate abortion methods for fetal protection in post-viability abortions where the abortion is performed to save the life or health of the mother	16
(b) The statutory mandate of Section 5(a) reflects the existence and availability of abortion methods capable of terminating pregnancy and producing a live birth	20
II. THE STATUTORY REQUIREMENT THAT A PHYSICIAN UTILIZE THE STANDARD OF CARE IF THERE IS SUFFICIENT REASON TO BELIEVE THAT THE FETUS MAY BE VIABLE IS A CONSTITUTIONALLY-PERMISSIBLE MANIFESTATION OF THE STATE'S COMPELLING INTEREST IN FETAL LIFE	25

Page

(a) The terminology "may be viable" correctly describes the statistical probability of fetal survival 25

(b) The terminology "may be viable" is clear and concise and capable of interpretation by the medical community 28

III. THE JUDICIARY HAS NO POWER TO DELINEATE LEGISLATIVE PRIORITIES IN REGULATING POST-VIABILITY ABORTIONS 32

(a) Constitutional Principles mandate judicial abstention in political questions of public policy 32

(b) The viable fetus diagnosed prenatally as defective has a right to life protectible by the state 37

CONCLUSION 43

TABLE OF AUTHORITIES

Cases

Page

Commonwealth v. Harmon Coal Co., 452 Pa. 77, 306 A.2d 308 (1973) 36

Connally v. General Construction Co., 269 U.S. 385 (1926) 29, 30

Doe v. Bolton, 410 U.S. 179 (1973) 13, 16, 30, 43

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Griswold v. Connecticut, 381 U.S. 479 (1965) 35, 36

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Lamm v. Volpe, 449 F.2d 1202 (10th Cir. 1971) 36

Lawton v. Steele, 152 U.S. 133 (1894) 36

Munn v. Illinois, 94 U.S. 113 (1876) 34

Planned Parenthood v. Danforth, 428 U.S. 52 (1976) 6, 13, 16, 18, 25, 26, 28, 30, 43

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State v. Whitaker, 335 U.S. 525 (1949) 36

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Wynn v. Scott, No. 75 C-3975 (E.D. N.D. Ill., filed April 12, 1978) 18, 21

Page

Younger v. Harris, 401 U.S. 37 (1971) 34

UNITED STATES CONSTITUTION

Amendment V 1, 37
Amendment IX 2
Amendment X 2
Amendment XIV 2, 37

STATUTES

28 U.S.C. §12353 1
Act of Sept. 10, 1974, P.L. 209, §2 ..... 4, 5
Act of Sept. 10, 1974, P.L. 209, §3(a) 5
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Act of Sept. 10, 1974, P.L. 209, §5(c) 5
Act of Sept. 10, 1974, P.L. 209, §5(d) 3
Act of Sept. 10, 1974, P.L. 209, §6(a) 5
Act of Sept. 10, 1974, P.L. 209, §6(b) 5, 13, 14, 16
Act of Sept. 10, 1974, P.L. 209, §6(c) 5
Act of Sept. 10, 1974, P.L. 209, §6(d) 5
Act of Sept. 10, 1974, P.L. 209, §6(f) 5
Act of Sept. 10, 1974, P.L. 209, §7 ..... 5, 6
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Page

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Page

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Page

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CITATION TO OPINIONS BELOW

The September 16, 1977 opinion issued by the three-judge court is not officially reported. The opinion and order were filed in the United States District Court for the Eastern District of Pennsylvania at Civil Action No. 74-2440.

The opinions of September 4, 1975 are reported at 401 F. Supp. 554 (1975), judgment vacated and remanded 428 U.S. 901 (1976).

All opinions are set forth in their entirety in the Appendix.

JURISDICTION

Title 28 U.S.C. §12353 confers jurisdiction on this Honorable Court to review by direct appeal an order restraining state officials from enforcing a state statute.

Upon consideration on remand by this Court, the district court on September 16, 1977 filed a memorandum opinion and issued an order declaring §5(a) of the Abortion Control Act unconstitutional and permanently enjoined appellants from enforcement of that provision. Appellants filed a Notice of Appeal to this Court on October 12, 1977.

CONSTITUTIONAL PROVISIONS INVOLVED

Fifth Amendment to the Constitution of the United States:

> "No person be held to answer to a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in

jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation."

Ninth Amendment to the Constitution of the United States:

"The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people."

Tenth Amendment to the Constitution of the United States:

"The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

Fourteenth Amendment to the Constitution of the United States, in pertinent part:

"Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

STATUTORY PROVISIONS INVOLVED

The pertinent portions of the Pennsylvania Abortion Control Act, P.L. 209 of 1974, 35 Pa. Stat. Ann. §6601, et seq., 4 Pa. Leg. Serv. 74, 625, are set forth below:

Section 5. Protection of life of fetus.

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

• • •

(d) Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section, or who violates subsection (b) of this section, shall be subject to such civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted.

1974, Sept. 10, P.L. 639, No. 209, §5, effective in 30 days.

QUESTIONS PRESENTED

I. May the Pennsylvania legislature constitutionally mandate a standard of care for the protection of viable unborn life when the abortion procedure is performed after viability?

II. Does the terminology "may be viable", which requires utilization of the standard of care, reflect the semantic difficulty of translating medical statistics into probabilities of survival in defining the achievement of viability and thus does not describe a time period prior to viability?

III. Does not the judiciary, absent a constitutional violation, lack the power to qualify the compelling state interest in viable fetal life where the mother's life or health is not at stake?

STATEMENT OF THE CASE

A. Procedural History

The Pennsylvania Abortion Control Act (Senate Bill 1318; Act 209 of 1974) was passed into law on September 10, 1974, to be effective within thirty (30) days of passage.

Appellees filed the class action complaint on September 20, 1974. The plaintiffs were Planned Parenthood of Southeastern Pennsylvania, a corporation involved in abortion referrals, and John Franklin, M.D., a physician who was designated as a representative of an alleged class composed of all Pennsylvania physicians who perform abortions. Dr. Franklin sought to assert the rights of the physicians as well as those of the physicians' female patients. On September 28, 1974, the court set the hearing on the motion for a preliminary injunction for October 9, 1974. On October 4, 1974, an amended complaint was filed and, in essence, added Concern for Health Options: Information, Care and Education, Inc. (CHOICE), and Clergy Consultation Service of Northeastern Pennsylvania as plaintiffs in this action. Both of these organizations operate abortion referral services. On October 9, 1974, after oral argument on the motion for preliminary injunction, the Obstetrical Society of Philadelphia, successfully moved to intervene as a plaintiff. By order dated September 4, 1975, the court granted Appellants' motion to dismiss Planned Parenthood, CHOICE and Clergy Consultation Service as plaintiffs in this action.[1]

The original complaint named the District Attorney of Philadelphia and the Secretary of Welfare as defendants.[2]

---

[1]Consequently, Planned Parenthood, CHOICE and Clergy Consultation Service have been eliminated from the caption of this case and are not identified as appellees before Your Honorable Court.

[2]At the time this action was commenced, Helene Wohlgemuth was the Secretary of Welfare of Pennsylvania. During the course of this litigation, she was replaced in that position by Frank S. Beal, who is designated as one of the appellants herein.

The Attorney General of Pennsylvania and the Commonwealth of Pennsylvania intervened as defendants in this action.

At the hearing on the motion for preliminary injunction, in spite of an Answer denying the plaintiffs' allegations, plaintiffs offered no testimony, affidavits or evidence of any nature in support of their contentions. Nonetheless, the three-judge court issued a preliminary injunction on October 10, 1974, which restrained the appellants from enforcing crucial provisions of the Act.

The trial of this case commenced on January 13, 1975 and continued for five full days, concluding on January 17, 1975. During the trial the court heard actual testimony from six witnesses for appellees and eleven witnesses for appellants. Additionally, the court received testimony by way of depositions from two witnesses and affidavits from an additional six witnesses. The majority of the witnesses called in this action were medical specialists, physicians, psychiatrists or social workers and, consequently elaborate expert testimony was elicited on all aspects of abortion procedures.

Judgment was rendered in this case on September 4, 1975. The court declared the Act to be severable and upheld the constitutionality of Section 2's definition of "informed consent", Section 3(a), Section 5(c), Section 6(a), Section 6(c) and Section 8. The lower court declared Section 2's definition of "viable", Section 3(b) (ii), Section 5(a), Section 6(b), Section 6(f) and Section 7 unconstitutional. In its Order, the Court ruled that a portion of 6(d) was constitutional and another portion of that section was unconstitutional. The full text of the Opinions and Order are set forth in the Appendix beginning at 154a.

Appellants in the instant appeal have previously appealed to this Honorable Court in a case styled ***Beal, Secretary of Welfare v. John Franklin, M.D., et al.***, filed at

No. 75-709 October Term, 1975. The appellees herein also appealed those portions of the lower court's judgment adverse to them in a case styled *Franklin, et al. v. Fitzpatrick District Attorney of Philadelphia, et al.*, filed at No. 75-772. Appellees' appeal was disposed of by this Court affirming the judgment in *Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

On July 6, 1976, appellants' prior appeal was disposed of by Order vacating the lower court's judgment and remanding the case:

> "The judgment is vacated and the case is remanded to the United States District Court for the Eastern District of Pennsylvania for further consideration in light of Planned Parenthood of Central Missouri v. Danforth, ___ U.S. ___ (1976); Singleton v. Wulff, ___ U.S. ___ (1976), and Virginia State Board of Pharmacy v. Virginia Citizen's Consumer Council, 425 U.S. ___ 1976. Mr. Justice Stewart and Mr. Justice White would note probable jurisdiction and set the case for oral argument."

After remand to the lower court, the parties entered into a Stipulation which disposed of all of the remanded issues with the exception of §5(a), the subject of this appeal, and §7 of the Act relating to governmental subsidy of abortions.[3]

The lower court found that §5(a) was violative of the United States Constitution in the Memorandum Opinion dated September 16, 1977, a copy of which is contained in the Appendix beginning at 254a.

B. Evidence at Trial Relating to Section 5(a)

In the court below, plaintiffs elicited testimony from two physicians who challenged the definition of "viability" as unclear and imprecise.

Dr. Louis Gerstley testified for plaintiffs that there are "too many variable factors that occur" in order to determine

[3]Appellees have not appealed the lower court's determination that Section 7 was constitutional.

if a particular fetus is viable (6a). Despite diagnostic tests, his judgment could be made "only roughly" (6a). In terms of gestational age, he would place viability at approximately 24 to 26 weeks' gestation at the earliest. He did not feel that the fetus born prior to 24 weeks gestation has any "reasonable chance of survival" which he defined as "at least on terms of five percent, and even by any extrapolation you may wish to use, certainly at least two to three percent" (8a). He would also allow for a margin of error of at least two weeks (R.31).

Dr. Gerstley further testified that for second-trimester abortions he preferred to use the method of saline amnio-infusion. He prefers the saline method over prostaglandins because "they have side effects ... that frequently are uncomfortable" (11a), might require repeated doses and "*there is the much greater incidence of the possibility of the fetus being born alive after a prostaglandin infusion, than there is with a saline*" (11a-12a).

It was Dr. Gerstley's further opinion that in order to deliver a 26-week viable fetus alive, he would use high dosages of oxytocin or perform a hysterotomy. He felt that a hysterotomy was "more immediate and less expensive and time-consuming" (13a) but felt that for the delivery of future children this mother would have to undergo a Caesarian section. He stated that his belief was "open to differing medical opinion" (13a).

On cross-examination, Dr. Gerstley stated that he wished the statute would define viability not only with gestational age but also with patient history and uterine size (17a). It was also his belief that *all* abortions, elective or not, have medical indications (R. 49). In questioning relating to a 1972 survey of the plaintiff Obstetrical Society of Philadelphia, Dr. Gerstley stated that the majority felt that abortions should not be performed beyond sixteen weeks gestation (R. 53). He later revealed, on redirect, that the overwhelming majority surveyed felt that *physicians or*

hospitals (as opposed to state legislature or federal government) *should regulate abortion practice* (19a).

Plaintiff Dr. John Franklin testified that at a diagnosed 24 weeks gestational age, a fetus had a 5% probability of survival but at 28 weeks had a "real probability" (20a). On cross-examination he admitted that "there is some increasing degree of viability or survival of the fetus" between 24-28 weeks (26a). He stated that he has found from his readings that physicians disagree with his views, but admitted on cross that these differences related to philosophical arguments over when life begins (25a). He felt that "as technical skills improve" the gestational age/survival ratio will improve (21a).

It was Dr. Franklin's opinion that in a mid-trimester abortion the fetus had the best opportunity for survival by use of the hysterotomy method. Complications would be limited to those attending any surgical procedure (23a). On cross, he testified that the saline procedure is fatal to the fetus but that the prostaglandin infusion stimulates uterine contraction rather than killing the fetus (28a). In terms of complications to the mother, he felt that the risk of health to the mother in a hysterotomy procedure was not great (29a) and was less life-threatening to the mother than a saline infusion (30a).

On cross-examination Dr. Franklin stated that the viability of each fetus must be determined on an individual basis. He testified that physicians "*cannot judge prior to delivery* except to arrive at some probability that I believe the mother is 26 or 28 or 24 weeks" (24a).

Dr. Franklin was concerned that neonatologists (specifically Dr. Mary Louise Soengten) would want him to use an abortion method which would save "the lives of very young immature babies". It was his emphatic opinion that if his woman patient wanted an abortion, he should be permitted to perform to it without being required "*by the*

State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus" (33a). The "vast sum of money" ... "certainly enter" into his decision (33a). However, where the child was wanted by the mother, he has taken steps toward maintaining the spontaneously aborted child's life (34a).

Dr. Hope Punnett, on behalf of the plaintiffs, directed her testimony to genetic counseling and the time frame within which testing can be completed. Dr. Punnett discussed two specific types of disorders which are identifiable prenatally: auto-somal disease (*e.g.*, Tay-Sachs) and chromosomal defect (*e.g.*, Down's Syndrome). The diagnostic procedure involves the removal of amniotic fluid from the sac by embryotic tap, growth of cells from the fluid, and testing of the cells for particular substances (50a).

Dr. Punnett testified that due to small uterine size, it is not feasible to obtain the amniotic fluid if the fetus is under 16 weeks' gestational age. If the cells from the fluid grow, the tests can be completed from two to six weeks (53a). The gestational age of the fetus approximated 18 to 20 weeks (53a). According to Dr. Punnett, there is the possibility that the cells will not grow and a second embryotic tap must be performed. Dr. Punnett expressed concern that hospitals might cut off abortions at twenty weeks' gestation when a small number of families might not yet have testing results completed. Of her own knowledge, she knew of only one case where testing exceeded twenty weeks gestation (58a).

On cross, Dr. Punnett explained that if both parents are Tay-Sachs carriers, there is a 25% chance that the child has Tay-Sachs. When asked about medicine's progress in treating genetic defects, Dr. Punnett expressed her personal viewpoint concerning the physician's role in advising the woman to carry the child to term: " ... if the child is salvageable ... (t)his is a family decision. It is not my decision to impose on the family" (63a).

In their case-in-chief, defendants presented Dr. Fred Mecklenburg who testified as to abortion methods and complications. With respect to saline infusion, he stated that the saline solution "almost invariably kills the baby" (36a) and has serious side effects for the mother: "The clotting mechanism of the person in a saline abortion is influenced 100 percent of the time" (38a). Some cases are severe and deaths have occurred. If the saline solution enters the mother's blood stream or into the abdominal wall, a hazardous condition occurs and lives have been lost (38a). In addition, risk of injury to the cervix, perforation of the bowel and the threat of infection exist (42a).

With respect to prostaglandin infusion, Dr. Mecklenburg described two methods of instillation. If given intravenously, there are high incidents of severe headaches, diarrhea and nausea. If administered into the uterus, the side effects are less severe. With the use of this method, the baby survives (37a).

Dr. Mecklenburg testified that during the hysterotomy, the baby is removed from the placenta through an incision in the mother's abdominal wall. The risks to the mother would be the same risks in any operative procedure utilizing anesthesia and incision of tissue (39a, 43a).

In the procedure known as the D & E, the cervix is forcibly opened, a powerful suction several times the atmosphere of the earth is introduced, and the fetus is reduced "to the consistency of crankcase oil" (35a). A long knife (curette) is generally then introduced to scrape out any remaining tissue (35a) in order to prevent hemorrhage (36a). Dr. Mecklenburg testified that this procedure is generally utilized for abortions prior to 7 weeks. Subsequent to 7 weeks, the fetal skeletal system begins to form and it is hazardous to extract bone from the mother's womb (39a-40a).

With respect to determining viability, on cross Dr. Mecklenburg stated that it is very difficult to determine in a

woman who is pregnant in the 20th to 28th week period. However, by examination of the patient, a physician could ascertain gestational age within 3 to 4 weeks (44a). Dr. Mecklenburg agreed with the statute's definition of viability, that it is current and takes into account medical progress (44a).

Dr. Thomas W. Hilgers, testifying on behalf of the defendants, described the short-term and long-term complications of the various abortion methods. With respect to saline infusion, Dr. Hilgers described infection, hemorrhaging and a high incidence of retained placental tissue which requires removal by curette (69a). In addition, a reaction that affects the blood's ability to clot occurs. In rare occasions major bleeding will occur, statistically low but significant because maternal deaths have occurred (71a).

With respect to prostaglandin infusion abortions, Dr. Hilgers testified that although research in prostaglandin use is in its infancy, he felt that it was as comparably safe as a saline infusion from a morbidity/mortality point of view (72a). He recommended the prostaglandin abortion as the best procedure for live delivery of a 4-1/2 to 5 month fetus weighing 400 grams (81a).

Dr. Hilgers described the hysterotomy procedure as having "the same problem as any major abdominal operation" (73a). He characterized the hysterotomy as having the highest mortality rate of all abortion procedures and cited infection and hemorrhage as primary complications. He felt that accepted medical practice would require all future children to be delivered by C-section (73a).

Dr. Hilgers described the immediate complications of the D & E method of abortion as infection, hemorrhage and perforation of the uterus or bowel (resulting in overwhelming abscesses, peritonitis, or anemia (64a-65a; 67a-68a). It was his opinion that this method carried the greatest risk of long-term complications: prematurity in subsequent preg-

nancies, longer labor and excessive bleeding in future pregnancies, greater incidence of ectopic pregnancies and infertility.

On cross-examination, Dr. Hilgers testified that although viability can never be determined accurately before the child's birth, some reasonable judgment can be made based upon patient history, size of infant, uterine size, gestational age, medical facilities in the community, and racial differences (77a-79a, 81a).

With respect to premature infants and the significance of mental and motor retardation, Dr. Hilgers cited recent advances leading to the prevention or decreased intensity of these difficulties (75a).

Dr. Arturo Hervada, board-certified pediatrician and Associate Chairman of Pediatrics at Jefferson Medical Center in Philadelphia, testified on behalf of the Commonwealth. Dr. Hervada stated statistical applications in medicine are constantly changing and abhorred a computerization in the practice of medicine (R. 583). However, with respect to viability and its determination, Dr. Hervada found no difficulty in visualizing any groups of competent physicians coming to a consensus regarding viability on any particular patient (R. 588, 595-596).

Dr. William Keenan, a board-certified pediatrician with a sub-specialty in neonatology, traced the development of human gestational development from conception to viability to birth. At the approximate gestational age of 26 weeks, Dr. Keenan identified the ability of the fetus for gas exchange and ventilation without dependence upon the placenta. At this particular stage of development, Dr. Keenan estimated a survival rate of 50% in premature infants (92a). It was his expert medical opinion that viability exists where a 10% anticipated rate of survival occurs (92a-93a). While Dr. Keenan described the determination of viability as a difficult one, he felt that competent medical practitioners

would agree substantially in their opinions concerning a particular patient (R. 552-553, 556, 572). On cross-examination, Dr. Keenan stated that prostaglandin infusion and C-section were both utilized for late abortions, but the decision to use one method over the other was clearly outside his medical expertise (R. 575-576).

The defendants additionally offered the affidavits of four obstetricians from the Philadelphia area to the effect that the statute's definition of viability "comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area, understand this term". In addition, these physicians averred under oath that they frequently are called upon to determine the viability of a fetus: a "relatively uncomplicated procedure" based upon patient history, clinical examination and medical judgment (Defendants' Exhibits W, X, Y and Z, R. 602, 145a-150a).

SUMMARY OF ARGUMENT

In full compliance with *Roe v. Wade*, 410 U.S. 113 (1973), *Doe v. Bolton*, 410 U.S. 179 (1973), and *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the Pennsylvania legislature in §5(a) of the Abortion Control Act mandated the use of a standard of care for post-viability abortions. This standard reflects the Commonwealth's compelling interest in viable unborn life and does not unconstitutionally invade the privacy of the abortion decision nor have a chilling effect thereon. In circumstances limited by §6(b) (to preserve the life or health of the mother), physicians may perform post-viability abortions.

Therefore, where the mother is entitled to a termination of her pregnancy in which the fetus has attained viability, the mother is not additionally entitled to have the viable fetus destroyed.

Physicians desiring to perform second-trimester abortions are *not* required to make a further judgment *other* than

viability. The medical determination of when a particular fetus achieves viability depends upon many factors, including statistical probabilities of survival based upon age and weight. The terminology used in §5(a) simply incorporates the flexibility required for sound medical practice.

The well recognized standards set forth in §5(a) are sufficiently definite. Physicians governed by §5(a) are clearly notified of the steps which must be taken for a post-viability abortion. Physicians are required simply to utilize the same degree of skill encountered in any other area of medical practice.

The state legislature is the proper arena for determining when and in what manner the state's compelling interest in protecting viable fetal life is manifested. Absent a violation of constitutional proportions, the judiciary has no power to set forth or strike down grounds for post-viability abortion. This principle of law remains constitutionally stable regardless of the genetic disease or chromosomal defect the viable fetus suffers.

ARGUMENT

INTRODUCTION

The facial question before the Court is whether the lower court erred in declaring unconstitutional the mandate of Section 5(a) which requires the physician who performs an abortion from viability onward (if permissible under Section 6(b)[4] to utilize the abortion technique best able to ensure the life of the fetus.

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[4]Section 6(b) proscribes abortions from viability onward in the following manner:

> Section 6. Control of Practice of Abortion
>
> (b) No abortion shall be performed within the Commonwealth of Pennsylvania during the state of a pregnancy subsequent to viability of the fetus except where necessary, in the judgment of a licensed physician, to preserve the life or health of the mother.

In the lower court, appellees successfully argued that the terminology utilized in §5(a) to describe a pre-condition to utilization of this standard of care was unclear and established an additional time period prior to viability during which abortions would be proscribed.

In addition, appellees set forth several challenges to §5(a) which the lower court did not rely upon in declaring this section unconstitutional: 1) that the effect of requiring protection for the unborn would have a chilling effect on the alleged right to choose an abortion and 2) that the pregnant woman seeking genetic counseling might not have the results in time for an abortion when her purpose is to destroy the fetus. Appellees have placed these issues before your Honorable Court in the Motion to Dismiss or Affirm.

The Commonwealth urges this Court to confine its inquiry to a review of the question of error by the lower court based upon the stated rationale. However, because appellees are raising these issues, the Commonwealth will extend the scope of this brief to a discussion of these additional arguments not only as a protective measure but chiefly to present the entire range of the ramifications of §5(a) to this Court for its edification. Also set forth is supporting medical and statistical data relevant to the inquiry.

It should be noted that the lower court struck down §5(a) in its entirety rather than merely the offending clause. Consequently, at present there is no legislatively-mandated protection for the unborn who is the target of a §6(b) abortion.

I. THE LOWER COURT ERRED IN DECLARING UNCONSTITUTIONAL THE MANDATE OF SECTION 5(a) WHICH REQUIRES THE PHYSICIAN WHO PERFORMS AN ABORTION FROM VIABILITY ONWARD TO PROTECT THE LIFE OF A FETUS.

a. The legislature has the power to regulate abortion methods for fetal protection in post-viability abortions where the abortion is performed to save the life or health of the mother.

This Court has recognized in *Roe v. Wade, supra, Doe v. Bolton, supra,* and *Planned Parenthood v. Danforth, supra,* that from viability onward the state's interest in the protection of prenatal life outweighs a woman's right to an abortion. Mr. Justice Blackmun, writing for the Majority in *Danforth*, emphatically stated that the Court in *Roe* rejected the premise "the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses". (428 U.S. at 60). Consequently this right of privacy "must be considered against important state interests" (428 U.S. at 61) in regulating the practice of abortion, including the state's compelling interest in protecting life subsequent to viability. The Commonwealth of Pennsylvania has recognized its compelling interest through the enactment of §5(a).

The ostensible question before this Court is whether the language in this section represents a constitutional implementation of this recognized and accepted state interest in protecting viable fetal life where the abortion itself is legislatively permitted under §6(b) in order to save the life or health of the mother.

It must be stressed initially that §5(a) does not in any way inhibit the performance of abortion, *i.e.*, the termination of pregnancy. Section 5(a) expressly provides that the protection of the life of the fetus must be subordinated to the needs of the mother if necessary to preserve the life or health of the mother.

Appellees argued below, however, that in effect, an abortion is not merely the termination of pregnancy. Since the mother does not want to carry the child to term, the appellee-physicians do not want to take any steps to preserve the life. At trial, appellee Dr. Franklin testified in this regard:

> Mr. Mansmann:
>
> Q. It is not your opinion that you as a physician ... should attempt to save the life of the child who can be saved?
>
> Dr. Franklin:
>
> A. I didn't say that. My opinion is that if the woman is seeking a termination of a pregnancy that I should be permitted to terminate her pregnancy. I should not be required by the State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus.

Dr. Franklin's views regarding the extent the law should concern itself with the preservation of life were frankly expressed in his deposition introduced at trial wherein he stated:

> Mr. Morris:
>
> Q. And do you agree that at some point — and this is probably your own philosophical reasoning — at some point there is an interest in the preservation of that fetus?
>
> A. Not necessarily. I have thought a lot about this question and I believe that life is extended to a fetus or a baby capable of living, if the baby is neglected in some way, that does not live, so that *one of the*

> *pre-requisites for life is that someone wants you to live*. It may be that they want you to live enough to start an i.v. or to put you on a breathing machine or ventilator but it simply may be that you can be brought into a household where you are fed and sheltered and clothed but the message is you are not wanted, and I believe there is good documentation of absence of growth in children for emotional reasons, namely, societal rejection, and there is a famous paper from the 30's of a nursery where babies were attempted to be raised in total asepsis, no bacteria at all, and these babies died because they were not handled, not talked to, in fact, neglected. *So my own philosophical definition of life necessitates other human beings who want you to live*. (85a-86a) (Emphasis added).

Appellees are presenting an issue of first impression to your Honorable Court with respect to the *per se* applicability of the standard of care to post-viability abortions.[5] An argument closely on-point was set forth in *Wynn v. Scott*, No. 75 C-3975 (E.D. N.D. Ill. filed April 12, 1978). In writing the Opinion of the three-judge statutory court, District Judge Marshall upheld an almost identically-worded statute:

> They contend that §6(1), though limited to abortions after the fetus is viable, improperly strikes the balance in favor of the fetus and against the woman. In essence, plaintiffs' position is that abortions after viability are permitted only when the woman's life or health is in jeopardy. In that situation, the physicians' primary concern should be in the health of the woman. Section 6(1) distracts the physician from caring for her needs. In fact, it requires the physician to sacrifice the woman for the unborn fetus, when the needs of the two conflict.

[5]In *Danforth* this Court was asked to strike a similar provision of the Missouri Act chiefly on the grounds it presumably applied to *all* abortions, regardless of the viability standard and not because of a "chilling effect" upon the constitutionally protected right of the woman.

> We disagree with this interpretation of §6(1). It does not require that the physician increase the risk to the woman in order to save the fetus. If, however, there are instances where a physician has a choice of procedures, both of equal risk to the woman, the physician must choose the procedure which is least likely to kill the fetus. This choice would not interfere with the woman's right to terminate her pregnancy. *It never could be argued that she has a constitutionally protected right to kill the fetus. She does not*. (Slip op. at 48-49). (Emphasis added.)

By way of footnote, Judge Marshall maintains that plaintiffs have agreed by implication that "when there is no conflict between the needs of the woman and the needs of the fetus, it is not improper for the state to insist that the physician be responsible for caring for the fetus as well as for the woman. Certainly the physician has the duty to care for both at a normal delivery" (Slip op. at 48 n.12).

Dr. Sissela Bok, a lecturer at Harvard Medical School, recently addressed this practical problem with the following conclusion:

> The termination of early pregnancy carries with it, at present, fetal failure to survive. But in later pregnancy, where abortion and death of the fetus do not necessarily go together, it is a fallacy to believe that a right to the first also implies a right to the second. I can maintain, then, without contradiction, that abortion is justified, but that if a live birth would result, it must be protected.
>
> Bok, The Unwanted Child: Caring for the Fetus Born Alive After An Abortion, Hastings Center Report, p. 12 (October 1976).

Dr. Bernard N. Nathanson, Chief of Obstetrics at St. Luke's Hospital, New York City, balances the woman's and the fetus' rights:

> The dimensions of this dilemma were exemplified by the *Edelin* case, which was a profound misunderstand-

> ing. Dr. Edelin regrettably labored under the same misapprehension that a great many obstetricians and pro-abortion advocates have labored under: that abortion necessarily implies the death of the products of conception. *It does not now and it never did. Abortion merely intends to remove the products of conception from the unwilling host.* And if one views abortion in that way — namely, that the woman's rights as the unwilling host are respected and that the products of conception are removed — then the fetus's rights . . . are also respected in that it is removed and cared for in the best manner possible.
>
> Nathanson, The Unwanted Child: Caring for the Fetus Born Alive After An Abortion, Hastings Center Report, p. 12 (October 1976). (Emphasis added).

Therefore, §5(a) does not unconstitutionally interfere with a mother's "right" to an abortion. The section merely implements the state's compelling interest in the protection of the unborn by putting the physician on notice to consider fetal viability in selecting the abortion *method* in post-viability abortions.

b. The statutory mandate of Section 5(a) reflects the existence and availability of abortion methods capable of terminating pregnancy and producing a live birth.

In the court below appellees attacked §5(a) on the additional ground that the abortion method best calculated to preserve fetal life after viability is not ever the method best for the woman. While appellees offered no testimony in this regard, appellants' witnesses described several methods capable of terminating the pregnancy and producing a live birth and delineated all of the potential complications. This testimony is set forth in detail in the Statement of the Case: B. Evidence at Trial Relating to Section 5(a), *supra*. Appellants respectfully submit that this standard of care is grounded in contemporary medical practice and is adaptable to the constant advancement and evaluation of medical

knowledge and technology. *Wynn v. Scott, supra*, slip op. at 50.

A review of the contemporary medical literature clearly reflects the existence of several alternative abortion techniques adaptable to mid-trimester pregnancy, with significantly varying risks and potential complications to the life and health of both mother and fetus. As appellants will demonstrate, the state of the art is such that all other things being equal, a competent physician can easily determine whether in any given case a procedure exists to safely abort a woman in a manner most conducive to the continuation of viable fetal life.

If abortion is selected during the mid-trimester, all medical authorities agree that the easiest and safest abortion techniques utilized in early pregnancies, with the fewest risks to life and health of the mother, *i.e.*, menstrual extraction, vacuum aspiration, and dilation and curettage) are no longer feasible abortifacients. *However, there are several methods available, all of which protect the life and health of the mother, but with dramatically different consequences to the possible survival of viable fetal life.*[6] Appellants will briefly review the available techniques, in descending order of their likelihood of aborting a live fetus.

HYSTEROTOMY

The hysterotomy is basically a caesarian section operative procedure and a recognized abortion alternative to live birth with the highest incidence of fetal survival of any of the abortifacients. Medical experience has shown that

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[6]Initially, it should be recognized that maternal life is best protected at least from the 16th week of gestation onward by carrying the fetus to term. See, National Center for Health Statistics, DHEW, Vital Statistics of the United States: Vol. 11, Mortality, 1972-1975, Standardized to Population of Women Obtaining Abortions in the United States. Table Six therein graphically illustrates the geometric raise in risk to maternal life in any abortion technique at the sixteenth week.

mid-trimester hysterotomy is characterized by a relatively high rate of fetal survival in comparison to fetuses aborted with prostaglandins and hypertonic saline infusion. William E. Brenner, M.D., University of North Carolina, Chapel Hill, N.C., OB-GYN Collected Letters, Series XV, p. 165, (November 1, 1974). It would appear, subject to continuing medical research and expanding knowledge in this area, that hysterotomy is the preferred procedure to induce a live birth.

PROSTAGLANDINS

A relatively recent innovation in abortifacients has been the use of prostaglandins. The result is achieved by intraamniotic injections of prostaglandins by syringe into the uterus, which stimulates uterine contractibility and induces labor, resulting in expulsion of the second trimester fetus through the cervix within thirty hours of injection. While there is some noted incidence of vomiting and diarrhea among women aborted by this method, it is generally conceded that prostaglandins are safe and effective for induction of abortion. Am. J. Obstet. & Gyn. 192:597 (1977), Studies Carried Out Under Steering Committee of the World Health Organization Task Force in Use of Prostaglandins for the Regulation of Fertility.

Prostaglandins appear preferable over saline injection due to decreased risk of cardiovascular failures, lack of coagulation effects, elimination of the risk of hyponatremia, and lack of tissue damage from inappropriate administration. Moreover, it is foreseeable that prostaglandin compounds will be developed that will have negligible side effects, with action restricted solely to the uterus. "Nursing Times", November 18, 1976, Nils Wiqvist, M.D., Stockholm, Sweden, Comments noted in OB-GYN Collected Letters, Series XV, p. 164-165 (November 1, 1974).

With reference to the physician's duty of care to the potentially viable fetus, it is accepted medically that the

incidence of a live born fetus is significantly greater on a statistical basis by use of the prostaglandin method over saline infusion injection. See also G. Stroh and A. R. Hinman, "Reported Live Births Following Induced Abortions: Two and One-Half Year's Experience in Upstate New York". Am. J. Obstet. & Gyn. 126:83 (1976).

SALINE AMNIOINFUSION

Also known as intraamniotic injection (IAI), this method of pregnancy termination involves the removal of amniotic fluid (amniocentesis) and instillation of a hypertonic 20% saline (sodium chloride) solution into the amniotic sac by a spinal needle inserted through the abdominal wall. The injected solution increases uterine activity such that expulsion of the fetus occurs usually between 17 and 35 hours after injection, usually resulting in the death of the fetus. Jaffin, Herbert, Thomas Kerenyi and E. C. Wood; Am. J. Obstet. & Gyn. 84:602 (1962).

The use of oxytocin by intravenous injection has been rated as a stimulant to a shorter injection-abortion interval. Schulman, Joseph D. and Niels H. Lauersen; The Lancet, 1:606 (1971). Also the use of other intraamniotic hypertonic agents, such as glucose and urea have been documented. Brosset, A., Obstet. Gynec. Scand. 37: 519 (1968); Greenhalf, J. O., Brit. Med. J. I:107, 1971.

Alternatives to saline injection are constantly being explored, due to reported complications; such as hypernatremia, renal failure, transplacental hemorrhage, pulmonary embolism, cardiovascular failure, endometritis, hypofibrinogenemia, necrosis, and severe vomiting. Howard Berk, M.D., "Complications of Intrauterine Instillation of Saline for Abortion, Contemporary OB/GYN Vol. 2, No. 6, p. 11-13; Wagatsuma, J., "Intraamniotic Injection of Saline for Therapeutic Abortion", Am. J. Obstet. & Gyn. 93:747 (1965); David H. Sherman, M.D., "Salting out: Experience in 9,000 Cases", J. Repro. Med. Vol. 14, No. 6,

pp. 241-243 (June 1974); Stephen R. Lenkin, M.D. and Herman E. Kattlove, M.D., "Maternal Death Due to DIC after Saline Abortion", Obstet. & Gyn. Vol. 42, No. 2, pp. 233-235 (August 1973). As the last source indicates, death resulting from any of the above complications is not unknown.

DILATION AND EVACUATION

D & E involves surgical removal of the fetus, accomplished with cervical dilation by graduated dilators and the use of crushing forceps or sharp curettage. The physician must crush and dismember the fetus piece by piece in the uterus, and reconstruct it after removal to insure completeness of the abortion procedure. The technique is being employed even in 16th to 20th week of pregnancy. "MDs Shun 16th Week D & E as Reminder of Destroyed Fetus", Medical Tribune, p. 9, Wednesday January 25, 1978; Judith Bourne Rooks and Willard Cates, Jr., "Emotional Impact of D & E vs. Instillation", Family Planning Perspectives, Vol. 9, No. 6 (November, December 1977).

OTHER METHODS

The above procedures are not the only known abortion methods. Among the techniques which have been used are utilization of phospholipids, serotonin and monoamine oxidase inhibitor pastes, extra-amniotic solutions, bougie and metreurynters. Techniques Applicable to Mid-trimester Abortion, Obstetrical-Gynecological Survey, 1974. However, the techniques discussed previously are those commonly utilized.

Appellees recognize the existence of a dispute among medical authorities on the relative safety and merits of the various procedures. Prostaglandins have proponents and the medical community also numbers advocates of D & E, hysterotomy, the use of oxytocins, and to a lesser degree, saline infusion.

The appellants submit that the only legally relevant considerations are that alternatives exist among abortifacients, and that the physician, mindful of the state's interest in protecting viable life, must make a competent and good faith medical judgment on the feasibility of protecting the fetus' chance of survival in a manner consistent with the life and health of the pregnant woman. The standard is one grounded in the present reality of abortion practice by use of hysterotomy and prostaglandins, and adaptable to the constantly expanding medical advances which the future may provide.

II. THE STATUTORY REQUIREMENT THAT A PHYSICIAN UTILIZE THE STANDARD OF CARE IF THERE IS SUFFICIENT REASON TO BELIEVE THAT THE FETUS MAY BE VIABLE IS A CONSTITUTIONALLY-PERMISSIBLE MANIFESTATION OF THE STATE'S COMPELLING INTEREST IN FETAL LIFE

a. The terminology "may be viable" correctly describes the statistical probability of fetal survival.

Section 2 of the Pennsylvania Act defines viability in the *precise* terms approved in *Roe* and clarified in *Danforth*.[7] Section 5(a), entitled "Protection of Life of Fetus", mandates, *inter alia*, protection of unborn life when in the experience, judgment and professional competence of the physician, there is sufficient reason to believe that the fetus may be viable.

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[7]Pertinent portions of Section 2 read as follows:

Definitions.—As used in this act:

• • •

"Viable" means the capability of a fetus to live outside the mother's womb albeit with artificial aid.

In the court below, appellees alleged that physicians were being required to make a *further* judgment beyond viability to a nebulous period denoted as the "may be viable" stage. Appellees argued that a gestational time period must be set so that physicians desiring to perform abortions would know with *absolute* certainty (not based upon their best medical judgment of the viability of a particular fetus but upon an inflexible time period) what was prohibited.

This Court in *Danforth* categorically and clearly rejected the notion that to be constitutionally valid a definition of "viability" must contain a reference to a gestational time period. The Court stated that it has recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability and that the flexibility of the term should be preserved.

The Commonwealth submits that the wording "may be viable" does not carve out an additional time period. It simply incorporates the flexibility necessary to place the protection of fetal life in a realistic context, and recognizes the inherent dilemma faced by a legislative body when articulating a cut-off point in fetal life after which that life is to be protected.

From a purely scientific point-of-view, it is clear that before birth no medical expert could guarantee 100% that a particular fetus, of any gestational age, will absolutely live outside the womb.[8] A physician can only predict, on the basis of statistical studies, that this fetus will be able to live after delivery.[9] In drafting terminology to accommodate this difficulty in hurdling the gap between medicine and law, the Pennsylvania legislature described this statistical problem in terms of "may be viable" language.

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[8]Appellee Franklin testified as to this inherent difficulty of prediction (24a), and appellants' witness Hilgers confirmed (77a).

[9]In this regard, the Commonwealth would draw the Court's attention to the expert medical testimony of appellants' witnesses Dr. William

(Continued)

In December of 1977, the American College of Obstetricians and Gynecologists strongly reaffirmed a statement of policy disseminated in December of 1975 with respect to ethical considerations in induced abortions. Clearly on point is the terminology which the College chose to use in describing the fetus:

Keenan and Dr. Arturo Hervada, both of whom stressed the fact that any determination of viability is based on many factors and involves an innate inexactitude.

Dr. Kennan, a board-certified pediatrician with a sub-specialty in neonatalogy, which deals with the care of an infant prior to delivery, exhaustively explained the current state of medical knowledge of human gestational development (R. 527-529). Dr. Keenan traced the progressive development of the human fetus from conception to the approximate gestational age of 26 weeks, at which point the fetus has developed the ability for gas exchange and ventilation without dependence upon the placenta. At this stage, he estimated a survival rate of 50% in premature infants (92a). It was his expert medical opinion that viability exists where a 10% anticipated rate of survival occurs (92a-93a). Appellee Franklin also stated that viability as understood by the medical profession occurs where the unborn child has a 10% chance of survival (R. 600).

Appellee Dr. Louis Gerstley testified that a "reasonable chance of survival is at least on terms of five percent, and even by any extrapolation you may wish to use, certainly at least two to three percent." (8a).

On a related point, Dr. Keenan explained that of babies born at 26 weeks gestation, only a small percentage have any mental or motor defects. But most importantly, fantastic progress is being made to correct and prevent these deficiencies. For a most recent update, see the fascinating article by Annabel Teberg, M.D., et al. entitled "Recent Improvement in Outcome for the Small Premature Infant" published in Clinical Pediatrics (Apr. 1977).

During the course of Dr. Keenan's practice he frequently found it necessary to make a determination of viability and in so doing utilized what he classified as the standard threefold test: menstrual history, external examination and his best medical judgment (93a-97a). He noted that even in a fully-equipped teaching hospital, viability cannot be ascertained with certainty in every case, due to variables such as sex and race, and possibilities that physical conditions of the woman, such as hypertension and diabetes, could affect fetal size (98a-100a). This would not be obviated by the use of amniotic fluid analysis (amniocentesis), sonar examination of crown-rump length or other advanced techniques which also contain sources for error (100a-101a).

> The College consequently recognizes a continuing obligation on the part of the physician towards the survival of *a possible viable fetus* where this can be discharged without additional hazard to the health of the mother.
> ACOG, Statement of Policy: "Further Ethical Considerations in Induced Abortions", p. 4 (December 1977). (Emphasis added.)

The College deliberately selected terminology which describes, as does the "may be viable" language of §5(a), the statistical probability of survival rather than the actuality of viability.

The Pennsylvania Legislature's use of the terms "may be viable", therefore, simply incorporates the acknowledged medical fact that a fetus is "viable" if it has that statistical "chance" of survival recognized by the medical community. This relative uncertainty but firm possibility of actual viability was recognized by this Court in *Danforth* when it stated:

> [I]t is not the proper function of the legislature or the Courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, ***and must be***, a matter for the judgment of the responsible attending physician. The definition of viability in Section 2(2)[10] hereby reflects this fact (428 U.S. at 64).

b. The terminology "may be viable" is clear and concise and capable of interpretation by the medical community.

Secondly, the Commonwealth avers that no practicable basis exists to define the physician's duty with any more

[10]Section 2(2) of the Missouri Act defined "viability" as "that stage of fetal development when the life of the unborn child ***may be*** continued indefinitely outside the womb by natural or artificial life-supportive systems" (428 U.S. at 84). (Emphasis added). Act of June 14, 1974, HCS House Bill 1211 §2(2), VAMS §188.015(3).

precision, and that such duty is no more onerous than that falling on other classes of fiduciaries or that which a physician encounters in any other area of medical practice.

The physician is required to follow two objective standards to avoid liability. First, prior to performing the abortion, he must make a determination that the fetus is viable or may be viable, based on his "experience, judgment or professional competence". Secondly, if such a determination is positive, he must attempt to preserve the life and health of the fetus through the exercise of "professional skill, care and diligence".

In the definitive article *The Void-For-Vagueness Doctrine in the Supreme Court*, 109 U. Pa. L. Rev. 67 (1960), Professor Freund was cited as having distinguished "three grades of certainty in the language of statutes of general operation: precisely measured terms, abstractions of common certainty, and terms involving an appeal to judgment or a question of degree". The "abstractions of common certainty" were those which had an "external object-referent" or a "pointing definition" and were "inherently capable of fixation", (109 U. Pa. L. Rev. at 90 citing Freund, *The Use of Indefinite Terms in Statutes*, 30 Yale L. J. 437 (1921).

It is submitted that the standards established in §5(a) are such "abstractions of common certainty". They do not rely on an ad hoc, erratic, subjective evaluation but instead incorporate and rely on firm, well-established professional medical judgment. As a result they notify physicians as to what conduct on their part is prohibited.

It is well established that any criminal act must be defined with appropriate definiteness. However, in the early case of *Connally v. General Construction Co.*, 269 U.S. 385 (1926), the Court noted that it is only necessary to set forth a firm standard of guilt so that men of common intelligence would not have to guess at its meaning.

> . . . [B]ut it will be enough for present purposes to say generally that the decisions of the court, upholding statutes as sufficiently certain, rested upon the conclusion that they employed words or phrases having a technical or other special meaning, well enough known to enable those within their reach to correctly apply them, *** or a well-settled common-law meaning, notwithstanding an element of degree in the definition as to which estimates might differ, *** or, as broadly stated by Mr. Chief Justice White in United States v. L. Cohen Grocery Co., 255 U.S. 81, 92, 41 S.Ct. 208, 301, (65 L.Ed. 516, 14 A.L.R. 1045), "That, for reasons found to result either from the text of the statutes involved or the subjects with which they dealt, a standard of some sort was afforded". (269 U.S. at 391-392).

The well recognized medical standards set forth in §5(a) are sufficiently definite under the rule stated by the Court in *Connally*. See also *Hynes v. Mayor and Council of Borough of Oradell*, 425 U.S. 610 (1976).

Similar medical standards in statutes allowing for criminal sanctions have previously been reviewed by this Court. Most recently in *Danforth*, your Honorable Court struck a similar criminal penalty only because the standard of care requirement upon which the penalty relied was over-inclusive. See note 6, *infra*.

In *Doe v. Bolton, supra*, a Georgia abortion statute was attacked as unconstitutionally vague in that criminal sanctions attached to the performance of an abortion except when it is "based upon (the physician's) best clinical judgment that an abortion is necessary" (410 U.S. at 200). It was alleged that the word "necessary" did not warn a physician of what conduct was proscribed, that the statute was wholly without objective standards and subject to diverse interpretations, and that doctors will choose to err on the side of caution and will be arbitrary (410 U.S. at 192).

The Court held that this determination of necessity was not so subjective and unpredictable as to void the statute.

The vagueness argument is set at rest by the decision in United States v. Vuitch, 402 U.S. 62, 71-72, 91 S. Ct. 1294, 1298-1299, 28 L.Ed.2d 601 (1971), where the issue was raised with respect to a District of Columbia statute making abortions criminal "unless the same were done as necessary for the preservation of the mother's life or health and under the direction of a competent licensed practitioner of medicine". That statute has been construed to bear upon psychological as well as physical well-being. This being so, the Court concluded that the term "health" presented no problem of vagueness. "Indeed, where a particular operation is necessary for a patient's physical or mental health is a *judgment that physicians are obviously called upon to make whenever surgery is considered*". *Id.*, at 72, 91 S.Ct. at 1299. This conclusion is equally applicable here.

Whether, in the words of the Georgia statute, "an abortion is necessary" *is a professional judgment that the Georgia physician will be called upon to make routinely*.

> We agree with the District Court, 319 F. Supp. at 1058, that the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. (410 U.S. at 191-192) (Emphasis added).

Similarly, §5(a) confines its scope to a medical setting where the rules of conduct are firmly established and where the standards are well known and where deviation from such standards can be determined without resort to conjecture.

Appellees additionally argued below that the absence of mathematical and semantic exactitude in §5(a) restrains them in the exercise of their medical practice and thereby interferes with the execution of their duties and their

patient's constitutional right to privacy.[11] The legal refutation of this argument is implicit in *Roe's* choice of viability as the threshold of compelling state interest. Despite patient request for and physician agreement to perform an abortion, the Supreme Court specifically stated that the state could forbid abortions at the point of viability except insofar as the life or health of the mother was concerned.

In addition, appellees' argument must be rejected in that to hold otherwise would deprive this section of any material effect. Such an interpretation would allow the physician to cavalierly, wrongfully and without fear of recourse, refuse to make a determination of viability in direct contradiction of the obvious intent of this section to exercise the state's compelling interest in protecting the life of a viable fetus. In the court below, appellee Gerstley, testifying on behalf of plaintiff Obstetrical Society, stated the Society's elitist view that *physicians and hospitals* should regulate abortion practice as opposed to the federal government or state legislatures! (19a)

III. THE JUDICIARY HAS NO POWER TO DELINEATE LEGISLATIVE PRIORITIES REGULATING POST-VIABILITY ABORTIONS

a. Constitutional Principles mandate judicial abstention in political questions of public policy.

In the lower court, appellees challenged the constitutionality of §5(a) on the additional basis that the legislature's ban on post-viability abortions is overly broad and violative of the woman's right of privacy and of the alleged right to genetic counseling to terminate the pregnancy of a defective fetus, and has an overall chilling effect on her constitutional rights as set forth in *Roe v. Wade*.

[11]See appellee Franklin's testimony excerpted in Argument I, *infra*, to the effect that he and his patient should *always* be the sole determinators of abortion practice and procedures.

The appellants submit that these arguments are wholly without merit. Nowhere in this Court's recent abortion decisions has your Honorable Court delineated any difference *whatsoever* in the state's compelling interest in viable fetal life based upon a diagnosed genetic defect or chromosomal disease.

Rather, this Court sanctioned the state's interest in *all* viable fetal life in opposition to the concept of abortion on demand:

> (c) For the stage subsequent to viability, *the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion* except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. *Roe v. Wade, supra,* 410 U.S. at 164-165. (Emphasis added).

The Court also stated:

> Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy. *The third reason is the State's interest — some phrase it in terms of duty — in protecting prenatal life.* 410 U.S. at 150. (Emphasis added).

The intention of the Court in *Roe* to reserve to state legislatures those areas of abortion regulation not subject to constitutional attack was made even clearer:

> Appellant and some amici argue that the woman's right is absolute and that she is entitled to terminate her pregnancy *at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.*
>
> We — conclude that the right to personal privacy includes the abortion decision, but that this right is *not unqualified* and must be considered against *important state interests in regulation.* 410 U.S. at 153-154. (Emphasis added).

Appellants respectfully assert that neither the statutory court nor your Honorable Court has the power to review the wisdom of a statute not penalizing the exercise of a fundamental right in an area of valid state interest, and that such is the case here. *Wyley v. Warden*, 372 F.2d 742 (4th Cir. 1967). Every favorably inference must be given the legislature in considering the constitutionality of an Act, with all doubts being resolved in their favor. *United States v. Vuitch*, 402 U.S. 62 (1971); *Munn v. Illinois*, 94 U.S. 113 (1876).

Appellees would have this Honorable Court mandate to the various States that, in regulating post-viability abortions, they must give weight to countervailing interests and considerations, including genetic counseling, diagnosis of forseeable birth defects, and other circumstances surrounding the conception and/or development of the child aside from the state's interest in protecting viable life. Appellees are asking this Court to indulge in blatant judicial legislation at variance with our basic constitutional framework as enumerated in the Ninth and Tenth Amendments. Appellees would have this Court transgress these enumerated powers and sit as a super-legislature, by specifying public policy considerations and guidelines for legislative action in the abortion field, thus thrusting the Court into political activity of the most fundamental sort.

In *Harrington v. State of Georgia*, 163 U.S. 299 (1896), the Supreme Court stated:

> The whole theory of our government, federal and state, is hostile to the idea that questions of legislative authority may depend . . . upon opinions of judges as to the wisdom or want of wisdom in the enactment of laws under powers clearly conferred upon the legislature. 163 U.S. at 304.

More recently, in *Younger v. Harris*, 401 U.S. 37 (1971), your Honorable Court reaffirmed the vitality of this concept:

> . . .[A] recognition of the fact that the entire country is made up of a Union of separate state governments, and a continuance of the belief that the National Government will fare best if the States and their institutions are left free to perform their separate functions in their separate ways. This, perhaps for lack of a better and clearer way to describe it, is referred to by many as "Our Federalism," . . . What the concept does represent is a system in which there is sensitivity to the legitimate interests of both State and National Governments, and in which the National Government, anxious though it may be to vindicate and protect federal rights and federal interests, always endeavors to do so in ways that will not unduly interfere with the legitimate activities of the States. It should never be forgotten that this slogan, "Our Federalism", born in the early struggling days of our Union of States, occupies a highly important place in our Nation's history and its future. 401 U.S. at 44-45.

Clearly, it is not for the judiciary to decide whether the legislature has chosen the best remedy to meet an evil. The courts decide only whether the means chosen are constitutional and related to the evil sought to be abolished. *Staten Island Loaders v. Waterfront Commission of New York Harbor*, 117 F. Supp. 308 (S.D. N.Y. 1953). In this instance, no one can reasonably dispute that the prohibition of Section 6(b) against abortions after viability unless the mother's life or health dictates otherwise, is a natural option reasonably related to the state's interest in protecting fetal life. So too is the mandate of §5(a) which sets forth utilization of a standard of care.

Unlike the birth control law in *Griswold v. Connecticut* 381 U.S. 479 (1965), the statute in this case pointedly legislates in an area of compelling state interest and does not invade the penumbra of a constitutionally protected right, *i.e.*, the privacy of the marriage relationship violated in *Griswold*. Questions regarding the quality of life versus consideration of the rights of viable fetuses, are questions of

public and not private morality once viability has attached. These questions inextricably involve the resolution of potentially competing societal interests of legally significant classes entitled to *legislative* concern. As Mr. Justice Douglas stated in the Opinion of the Court in *Griswold, supra,* "we do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch upon economic problems, business affairs, or social conditions". *Griswold v. Connecticut, supra,* 381 U.S. at 481.

An examination of this question from the other side of the coin, *i.e.*, the appropriateness of state action, aside from the inappropriateness of federal intervention, reveals that §5(a) is a valid exercise of the state's police power.

The "Police Power" of a state arises out of the reservation of powers contained in the Tenth Amendment. *State v. Whitaker,* 335 U.S. 525 (1949). It is a matter of legislative prerogative in which the legislature has wide discretionary powers; it includes that which is essential to public safety, health and morals. *Lamm v. Volpe,* 449 F.2d 1202 (10th Cir. 1971). The classic statement of the parameters of this power was enunciated in *Lawton v. Steele,* 152 U.S. 133 (1894):

> To justify the State in thus interposing its authority in behalf of the public, it must appear, first, that the interests of the public generally, as distinguished from a particular class, require such interference; and, second, that the means are reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals. 152 U.S. at 137.

This statement has been repeatedly cited and adopted in more recent cases. *Goldblatt v. Town of Hempstead,* 369 U.S. 590, 594-95 (1962); *Sweeney v. Murphy,* 39 App. Div.2d 306, 308, 334 N.Y. S. 2d 239, 241(1972); *Commonwealth v. Harmon Coal Co.,* 452 Pa. 77, 93, 306 A.2d 308, 317 (1973). Under these criteria, §5(a) is clearly a proper exercise of the state's police power.

The threshold question of state interest in the viable fetus, as an appropriate focus of public concern, was answered in *Roe v. Wade, supra.* The means selected to implement this concern is indeed the *only conceivable means* to effect the proper purpose of protecting prenatal life, *i.e.*, prohibiting abortifacient techniques that endanger viable life. There is simply no way the state can countenance, for example, a dilation and evacuation abortion of a viable fetus, absent medical necessity, if alternative medical procedures, in the best judgment of the physician, could result in a live birth. To permit otherwise would be to abandon totally the statutory purpose of protecting viable life, which this Honorable Court states may even be viewed as the state's *duty*! *Roe v. Wade, supra,* 410 U.S. at 150.

b. The viable fetus diagnosed prenatally as defective has a right to life protectible by the state.

With regard to congenital diseases and birth defects, appellees argue that the pain and suffering visited upon the parents and the child born with a progressively degenerative and fatal disease renders §5(a) of the Act oppressive by requiring the birth of a fetus so diagnosed at the latter stages of pregnancy. Appellees' approach would sanction (albeit out of compassion for the parents and presumably for the fetus[12]) state action effecting the termination of genetically "disfavored" life.

The Commonwealth asserts initially that testing for genetic defects or diseases is for the most part completed *prior* to the attainment of viability by the fetus.[13] If, however, the testing is not completed until after viability, the

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[12]To support their position, appellees must, however, argue that there are instances where death is preferable to life, notwithstanding the fact that the terminated, legally-recognized being has no choice in the decision and no culpability leading to the irreversible decision to abortion, a clear violation of the Fifth and Fourteenth Amendments.

[13]At trial appellees offered the testimony of Hope Punnett, a genetic counselor, for the alleged purpose of demonstrating that if an interpreta-

(Continued)

state's compelling interest in protecting that life is paramount.

Consequently, it is important to examine the procedure by which prenatal diseases or defects are diagnosed and the time frame within which testing is completed.

There are approximately 150,000 babies born each year in the United States with congenital malformation, half of which causes significant developmental disabilities. Mitchell S. Golbus, M.D., "Prenatal Diagnosis of Genetic Disorders", Contemp. OB/GYN Vol. 7 (Jan. 1976).

Some of the defects can be diagnosed prenatally through the use of a technique known as amniocentesis. Amniocentesis is a procedure by which a sample of the amniotic fluid surrounding the fetus is removed and tested. John S. O'Brien, M.D., "Tay-Sachs Disease: Prenatal Diagnosis", Contemp. OB/GYN. Vol. 3 (Dec. 3, 1976). The cells in the amniotic fluid are cultured and used for chromosome studies and examined for enzyme deficiencies and other evidence of genetic defects. Golbus, *supra*. The procedure has been used to determine the existence of certain fetal chromosome abnormalities (including Down's

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tion of §5(a) set viability at 20 weeks, some couples would be denied the "option" of genetic counseling. Appellants asked for an offer of proof and challenged the testimony as irrelevant. Appellants later moved to strike this testimony but the motion was denied.

However, there was no testimony presented which set viability at 20 weeks. There was extensive testimony that the viability of each individual baby must be determined on the circumstances peculiar to mother and child utilizing reasonable medical judgment. Testimony revealed that it is impossible to utilize gestational age alone in determining viability. Commonwealth witnesses, when pressed to do so, generally spoke of the 26-28 week viable baby.

Dr. Punnett's testimony revealed only one instance where the diagnostic tests were not completed in time for the woman to have an abortion prior to 20 weeks' gestation. That particular abortion was performed at 18-22 weeks' gestation.

Consequently, if the fetus who is the subject of genetic counseling is not viable, the Pennsylvania Act would not prohibit an abortion.

Syndrome); neural tube defects; metabolic disease (including Tay-Sachs); and X-linked diseases (at least to the extent it identifies the sex of the fetus). Nancy E. Simpson, Ph.D., *et al.*, "Prenatal Diagnosis of Genetic Disease in Canada: Report of a Collaborative Study", CMA Journal, 115:739 (Oct. 23 1976).

Amniocentesis is not performed without risk. Although it has been shown to be a generally safe, accurate and reliable procedure, it should be monitored by ultrasonography to better determine fetal and placental placement, performed by a trained obstetrician and carried out in a major health service center, Simpson, *supra*. The risks associated with transabdominal amniocentesis involve those to the mother (blood group sensitization, infection and intra-abdominal bleeding) and to the fetus (injury inflicted by the needle, abortion and possibility of an induced malformation, Golbus, *supra*.

Maternal complications, including spontaneous abortion, within 72 hours of amniocentesis occurred in 3.6% of the 1,223 amniocentesis studies in Canada between 1972 and 1975, Simpson, *supra*.

> It should be emphasized that the amniocentesis is a procedural endpoint and must be preceded by the careful recording of a family pedigree and appropriate genetics counseling, ... (emphasizing) not only the risk of having a genetically defective infant but also the dangers of amniocentesis. Golbus, *supra*.

Amniocentesis is also performed on so-called high-risk mothers, *i.e.*, those who are over 40 years of age, or have other children with genetic defects, (Simpson, *supra* and Golbus, *supra*), or who are members of a sub-group which is known to have a high percentage of carriers of genetic disease such as Tay-Sachs. O'Brien, *supra*.[14]

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[14]According to a study of over 27,000 pregnancies in Charleston, South Carolina, approximately 1.6% of pregnant women are over 40 years

(Continued)

In order to allow for sufficient development of fetal cells and the presence of an adequate quantity of amniotic fluid, the amniocentesis should not be performed until mid-trimester of pregnancy, preferably not before the fifteenth or sixteenth gestational week (Simpson, *supra).*[15]

Two or three weeks are required to grow enough cells for chromosomal studies, and two weeks more are required to grow enough cells for biochemical analysis (Simpson, *supra*). This time table would allow adequate time to perform an abortion with the intention of destroying the fetus before viability is reached.[16]

It is not appellants' purpose to denigrate the tragic situation which befalls the family of one born with severe mental and motor retardation or debilitating disease. The Commonwealth's position remains firm that the aims of the law must be to nurture that viable life and the family which

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old, and the incidence of Down's Syndrome in women of this age group is one in sixty. Edgar O. Harger III and Alexander R. Smythe II, "Pregnancy in Women over Forty", Obst. & Gyn. 49:257 (1977).

Overall there are approximately 5,000 Down's Syndrome babies born each year. Maya Pines, "Heredity Insurance", The New York Times Magazine, (4/30/78). The frequency of chromosome abnormality, including Down's Syndrome, in mothers over 40 has been estimated as high as one in twenty, with the risk increasing in women between 35-39 to one in sixty (Simpson, *supra*, and Golbus, *supra)*, and in women under 35 one in six hundred (Pines, *supra)*. It has been estimated that there is a one in one hundred chance that women over 35 who have had a child with chromosome abnormality will have another (Simpson, *supra)*. Finally, before genetic testing for Tay-Sachs disease began in the United States only 50 to 60 cases of this disease occurred annually (Pines, *supra*).

[15]Dr. Golbus states that it is now his practice to perform amniocentesis at 15 *menstrual* weeks (13 gestational weeks). (Golbus, *supra* at 119).

[16]In the Canadian study of 1,223 amniocentesis procedures, only one amniocentesis was needed for diagnosis in 84% of the pregnancies; of the 1,020 pregnancies studied, only 3.7% of the amniocentesis were inconclusive due to culture failure (Simpson, *supra*).

surrounds it so that it might reach its fullest potential in the complete enjoyment of its constitutional guarantees.[17]

In light of the almost daily advances being made through medical research not only in earlier diagnosis but in the treatment of supposedly untreatable and irreversible terminal diseases, appellants strongly urge this Court to refrain from mandating a justification for post-viability abortions entitled "Genetic Disease or Defect". Determination of which genetic defects are so serious or so incurable and tragic as to warrant the death of the viable fetus who through chance of nature happens to possess that defect is of such proportion as to defy the ability of judgment of mortals. At a conference sponsored by the Hastings Center and the National Institutes of Health, some 85 scientists, philosophers, lawyers and theologians met in October of 1971 to discuss ethical questions raised by genetic counseling. As Joan Lynn Arehart describes in Science News, 100:298-300 (Oct. 30, 1971):

> Yet, even if one decides when a fetus becomes human, there is the thorny question of what constitutes a genetically sound person. Every American carries at least 5 to 10 defective genes, according to Kayback, another alumnus of the Hastings conference. Lederberg admitted that being a Nobel laureate, as he is, assures even him no passport into the realm of normalcy. In fact, most panelists present uncomfortably agreed that had a treatment not been found for PKU babies several years ago, PKU victims might today be included on the defective fetus-abort list. Carried to its logical conclu-

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[17]Supportive government health and welfare services are available to families so situated in Pennsylvania, free of charge or at nominal cost, to ease the burden of such child-rearing. The federal food stamp program, certain social security benefits, and the aid to dependent children, and public assistance programs are but a few of the existing governmental resources, federal state and county.

If the family does not desire to keep the child, the adoption alternative is available, in addition to placement of the child in foster homes, and state-financed child care shelters.

> sion, some participants prophesized, there is reason to believe that all human "defectives", Rh negatives and left-handers alike, might eventually be defined out of the human chromosome lottery.

See also the numerous questions raised in Amitai Etzioni's "Amniocentesis: A Pandora's Box", Medical Opinion, p. 53 (Aug. 1976). Dr. Etzioni succinctly argues at p. 54:

> Will this turn society into a Nazi-like biologistic and racist camp that focuses on people's genetic qualities instead of their efforts and achievements?

It is interesting to note that both the Pennsylvania Governor's Abortion Law Committee of 1972 and the Pennsylvania Legislature heard testimony from organizations for the retarded and handicapped — none of whom testified in favor of abortion as the answer to their problems.

While there is not a person who does not sympathize with a retarded or handicapped child and that child's family because of the great burden they face — who is to say to that child that his quality of life does not meet the "community standard" because he is different.[18] The questions medically, morally and philosophically are endless, troubling and frightening in implication.

The legislature in this instance chose not to take the smallest step down the path of genetic or social selections formerly trod by the ancient Spartans, who history tells us laid the weakest new-born infants on the hillsides of Sparta to die, supposedly to insure the development of a healthy and superior warrior race. Appellants are not persuaded that

[18]An additional issue should be considered with respect to the severe psychological impact a sanctioning of abortion for viable "defective" life would have on handicapped members of society who might feel that society has placed a negative value on their right to life and that were they conceived presently or in the near future, they would not be permitted to live.

our constitutional traditions would permit such a development. However, it is even more certain that nothing in our constitutional system compels such a result. If this type of evolution is to transpire, it is a question of public policy to be made by the body politic and not the courts.

This Court has drawn the line in determining a person's right to life, by constitutional interpretation, at viability. The Commonwealth strongly urges your Honorable Court to stand firm with respect to viability by reaffirming in this regard the precedents of *Roe v. Wade*, *Doe v. Bolton* and *Planned Parenthood v. Danforth*.

CONCLUSION

It is respectfully requested that your Honorable Court reverse the judgment below and reinstate §5(a) of the Abortion Control Act in full force and effect.

In lieu thereof, appellants request that the terminology "or may be viable" be severed and that the remainder of §5(a) be reinstated in full force and effect.

Respectfully submitted,

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Special Assistant Attorney General

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IN THE

Supreme Court of the United States

October Term, 1977.

No. 77-891.

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,
Appellants,

v.

JOHN FRANKLIN, M.D. and
OBSTETRICAL SOCIETY OF PHILADELPHIA,
Appellees.

On Appeal From the United States District Court for the Eastern District of Pennsylvania.

BRIEF FOR APPELLEES.

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INDEX.

	Page
COUNTERSTATEMENT OF QUESTIONS PRESENTED	1
COUNTERSTATEMENT OF THE CASE	2
I. Introduction	2
A. Procedural History	2
B. Summary of Testimony Pertaining to Section 5(a)	4
SUMMARY OF ARGUMENT	9
ARGUMENT	11
I. Section 5(a) Unconstitutionally Restricts the Abortion Decision in the Interest of Fetal Life Prior to Viability; the Provision Is Overbroad	11
II. Section 5(a) Is Void for Vagueness	15
A. The Terminology "May Be Viable" Fails to Inform the Physician When His Duty Toward the Fetus Arises	15
B. The Statute Fails to Afford Physicians Discretion in Determining Which Abortion Technique Is Appropriate	22
III. Section 5(a) Unconstitutionally Restricts a Couple's Right to Conceive and Bear Their Own Biological Children	27
CONCLUSION	35

TABLE OF CITATIONS.

Cases:	Page
Abele v. Markle, 342 F. Supp. 800 (D. Conn. 1972), vacated, 410 U. S. 951 (1973), reh. denied, 411 U. S. 940, on remand, 369 F. Supp. 807 (D. Conn. 1973)	32
Beal, Secretary of Welfare v. John Franklin, et al., No. 75-709 (October Term, 1975)	4
Blount v. Rizzi, 400 U. S. 410 (1971)	35
Champlin Ref. Co. v. Commission, 286 U. S. 210 (1932)	16
Cline v. Frink Dairy Company, 274 U. S. 445 (1927)	15
Commonwealth v. Harmar Coal Company, 452 Pa. 77, 306 A. 2d 308 (1973), appeal dismissed, 415 U. S. 903 (1974)	34
Connally v. General Const. Company, 269 U. S. 385 (1926)	16
Doe v. Bolton, 410 U. S. 179 (1973)	11, 32
Doe v. Mundy, 378 F. Supp. 731 (E. D. Wisc. 1974), stay denied, 419 U. S. 813, aff'd., 514 F. 2d 1179 (7th Cir. 1975)	12
Doe v. Rampton, 366 F. Supp. 189 (D. Utah), vacated and remanded, 410 U. S. 950 (1973)	13
Doe v. Zimmerman, 405 F. Supp. 534 (M. D. Pa. 1975)	21
Dunne v. United States, 138 F. 2d 137 (8th Cir.), cert. denied, 320 U. S. 790, reh. denied, 320 U. S. 814 (1943), reh. denied, 320 U. S. 815 (1944)	35
Franklin et al. v. Fitzpatrick, District Attorney of Philadelphia, et al., No. 75-772 (October Term, 1975)	4
Grayned v. City of Rockford, 408 U. S. 104 (1972)	16
Griswold v. Connecticut, 381 U. S. 479 (1965)	11, 15, 34
Goldblatt v. Town of Hempstead, 369 U. S. 590 (1962)	33
Hennington v. State of Georgia, 163 U. S. 299 (1896)	33
Hodgson v. Anderson, 378 F. Supp. 1008 (D. Minn. 1974), appeal dismissed sub nom. Spannus v. Hodgson, 420 U. S. 903 (1975)	12
Hodgson v. Lawson, 542 F. 2d 1350 (8th Cir. 1976)	15
Lamm v. Volpe, 449 F. 2d 1202 (10th Cir. 1971), cert. denied, 405 U. S. 1075 (1972)	32
Lanzetta v. New Jersey, 306 U. S. 451 (1939)	16

TABLE OF CITATIONS (Continued).

Cases (Continued):	Page
Lawton v. Steele, 152 U. S. 133 (1894)	33
Lincoln Union v. Northwestern Company, 335 U. S. 525 (1949)	33
McLaughlin v. Florida, 379 U. S. 184 (1964)	11
Munn v. Illinois, 94 U. S. 113 (1876)	33
NAACP v. Alabama, 377 U. S. 288 (1964)	11, 15
Nyberg v. City of Virginia, 495 F. 2d 1342 (8th Cir.), appeal dismissed, 419 U. S. 891 (1974)	13
Planned Parenthood of Cent. Mo. v. Danforth, 428 U. S. 52 (1976)	14, 17, 23, 27
Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (E. D. Pa. 1975)	4
Planned Parenthood Association, et al. v. F. Emmett Fitzpatrick, Jr. and Frank S. Beal, No. 74-2440 (September 16, 1977)	2
Roe v. Wade, 410 U. S. 113 (1973)	9, 11, 12, 13, 14, 16, 20, 33, 34, 35
Skinner v. Oklahoma, 316 U. S. 535 (1942)	30
Staten Island Loaders v. Waterfront Commission, 117 F. Supp. 308 (S. D. N. Y. 1953), aff'd., 347 U. S. 439 (1954)	33
Sweeney v. Murphy, 39 App. Div. 2d 306, 334 N. Y. S. 2d 239 (1972)	34
United States v. Vuitch, 402 U. S. 62 (1971)	20, 22
Winters v. New York, 333 U. S. 507 (1948)	16
Wyley v. Warden, 372 F. 2d 742 (4th Cir.), cert. denied, 389 U. S. 863 (1967)	33
Wynn v. Scott, No. 75 C-3975 (E. D. Ill., April 12, 1978)	15, 23, 26, 27
Young Women's Christian Association of Princeton, N. J. v. Kugler, 342 F. Supp. 1048 (D. N. J. 1972), vacated and remanded, 475 F. 2d 1398, aff'd., 493 F. 2d 1402 (3rd Cir.), cert. denied, 415 U. S. 989 (1974)	12
Younger v. Harris, 401 U. S. 37 (1971)	32
Yu Cong Eng v. Trinidad, 271 U. S. 500 (1926)	35

TABLE OF CITATIONS (Continued).

Statutes: Page

Fourteenth Amendment, Due Process Clause 27
Model Penal Code § 230.3(2) (Master Edition 1974) 31
Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P. S. § 6601 et seq.:
Section 2 ..... 3, 17
Section 3(b)(i) and 3(b)(ii) 3
Section 5(a) 1, 2, 4, 7, 9, 13, 14, 15, 16, 17, 22, 27, 30, 34, 35
Section 5(d) 17, 19, 22
Section 6(b) 3
Section 6(f) 3
Section 7 ..... 3, 4

Miscellaneous:

E. Freund, "The Use of Indefinite Terms in Statutes," 30 Yale L. J. 437 (1921) 21, 22
J. Greenhalf and P. Diggory, "Induction of Therapeutic Abortion by Intra-amniotic Injection of Urea," Brit. Med. J. 1:28 (1971) 24
C. Kindregan, "Eugenic Abortion," Suffolk U. L. Rev. 3:406 (1972) 31
S. Lemkin and H. Kattlove, "Maternal Death Due to DIC After Saline Abortion," Obstet. and Gyn. 42:233 (August, 1973) 24
Manual of Medical Standards and Guidelines, Section VII-A, Planned Parenthood Federation of America 23
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J. Pritchard and P. McDonald, Williams Obstetrics (15th ed. 1976) 13
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TABLE OF CITATIONS (Continued).

Miscellaneous (Continued): Page

N. Simpson, et al., "Prenatal Diagnosis of Genetic Disease in Canada: Report of a Collaborative Study, CMA Journal 115:739 (1976) 28
Note, "The Void-for-Vagueness Doctrine in the Supreme Court," 109 U. Pa. L. Rev. 67 (1960) 15
T. Wagatsuma, "Intra-amniotic Injections of Saline for Therapeutic Abortions," Am. J. Obst. & Gynec. 93:743 (November 1, 1965) 24
World Health Organization Task Force, "Prostaglandins and Abortions," Am. J. Obstet. Gynecol. 129:597 (November 15, 1977) 25, 26

COUNTERSTATEMENT OF QUESTIONS PRESENTED.

I. Was Not the Court Below Correct in Determining That Section 5(a) of the Abortion Control Act Unconstitutionally Restricts the Abortion Decision Prior to Viability?

II. Is Not the Terminology "May Be Viable" and the "Technique Which Would Provide the Best Opportunity for the Fetus to Be Aborted Alive" Void for Vagueness?

III. Does Not the Requirement That No Abortions Be Performed When the Fetus "May Be Viable" Unless Necessary to Preserve the Woman's Life or Health Unconstitutionally Restrict a Couple's Right to Conceive and Bear Their Own Biological Children?

COUNTERSTATEMENT OF THE CASE.

I. Introduction.

This is an appeal from the decision of a 3-judge court in the Eastern District of Pennsylvania, holding that Section 5(a) of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P. S. § 6601 *et seq.*, 6605 ("the Act"), is unconstitutional and enjoining defendants, their agents, employees, successors in interest, and all others acting in concert with them, from enforcing that section. *Planned Parenthood Association, et al. v. F. Emmett Fitzpatrick, Jr. and Frank S. Beal,* No. 74-2440 (September 16, 1977). (239a-244a)

Appellants are Frank S. Beal, Secretary of Welfare of the Commonwealth of Pennsylvania; Robert P. Kane, Attorney General of the Commonwealth of Pennsylvania; The Commonwealth of Pennsylvania; and F. Emmett Fitzpatrick, formerly District Attorney of Philadelphia.

Appellees are John Franklin, M.D., a Board-certified obstetrician and gynecologist and the Obstetrical Society of Philadelphia, a voluntary association of Board-certified obstetricians and gynecologists.

A. Procedural History.

This case arose out of Appellees' successful challenge to the constitutionality of numerous provisions of the Pennsylvania Abortion Control Act, known as Senate Bill No. 1318, Session of 1973. This Act was passed by the Legislature of Pennsylvania over Governor Shapp's veto and was expressed to be effective October 10, 1975.

On September 20, 1974, Appellees and others filed a Complaint challenging the Act.[1] The plaintiffs included Planned Parenthood Association of Southeastern Pennsylvania, Inc., a non-profit corporation which provides family planning services, and John Franklin, M.D., a Board-certified obstetrician and gynecologist who is the Medical Director of Planned Parenthood. Dr. Franklin performs abortions and counsels patients with regard to family planning.[2] The defendants were F. Emmett Fitzpatrick, Jr., then District Attorney of Philadelphia County and Helen Wohlgemuth, then Secretary of Welfare of the Commonwealth of Pennsylvania.[3]

1. The Complaint was subsequently amended on October 3, 1974 and December 10, 1974.

A three-judge District Court was convened on September 12, 1974.

On October 10, 1974, in response to Plaintiff's Motion for a preliminary injunction, the three-judge Court restrained the enforcement of various provisions of the Act, including Section 5(a).

Following discovery and class action certification, the final hearing on the merits was held from January 13, 1975 through January 17, 1975.

Extensive expert medical testimony was presented by both sides.

On September 4, 1975, the court declared the Act severable and held the following sections unconstitutional:

Section 2's definition of "viable";
Section 3(b)(i) and 3(b)(ii);
Section 5(a);
Section 6(b);
Section 6(f); and
Section 7.

2. The Obstetrical Society of Philadelphia, designated an Appellee herein, was granted leave to intervene as a plaintiff on October 9, 1974.

3. Frank S. Beal replaced Ms. Wohlgemuth in that position during the course of the litigation. He is designated as one of the Appellants herein.

The Attorney General of Pennsylvania and the Commonwealth of Pennsylvania, also designated as Appellants herein, intervened following the final hearing.

Defendants were enjoined from enforcement of those sections. (238a) *Planned Parenthood Association v. Fitzpatrick*, 401 F. Supp. 554 (E. D. Pa. 1975; 3-judge court).

Both parties appealed to the Supreme Court of the United States, *Beal, Secretary of Welfare v. John Franklin, et al.*, No. 75-709 (October Term, 1975); *Franklin, et al. v. Fitzpatrick, District Attorney of Philadelphia, et al.*, No. 75-772 (October Term, 1975), which vacated the judgment and remanded

> "for further consideration in light of *Planned Parenthood of Central Missouri v. Danforth*, 428 U. S. — (1976); *Singleton v. Wulff*, 428 U. S. — (1976) and *Virginia State Board of Pharmacy v. Virginia Citizen's Consumer Council*, 425 U. S. — (1976)." (240a) 428 U. S. 901 (1976).

All of the remanded issues except Section 5(a) and Section 7 [4] were resolved by stipulation of counsel.

On September 16, 1977, after reconsideration of Section 5(a), the court

> "adhere[d] to [its] original view and decision that section 5(a) is unconstitutional." (241a)

Appellants thereupon filed the present appeal, seeking a reversal of the three-judge court's decision.

B. Summary of Testimony Pertaining to Section 5(a).

Medical testimony in the court below established that it is impossible to determine whether a particular fetus is viable while it is still in the womb well into pregnancy. (6a-7a; 19a; 43a-44a; 71a-80a; 93a-101a; 111a-112a; 120a-123a; 137a-138a; 141a-142a)

4. Section 7 concerns government subsidy of abortion. It is not challenged in the present appeal.

There is no direct test for determining viability. Physicians rely upon the woman's often inaccurate report of her menstrual history (96a-97a) and an external examination. (94a) Maternal health and nutrition, race, sex, and the facilities of the hospital are also taken into consideration. (78a; 100a-101a; 112a)

As Dr. Louis Gerstley testified upon behalf of Appellees, there are too many variables involved to enable more than a "rough" estimation of viability. (6a)

Appellants' witness Dr. William J. Keenan confirmed that it is a "soft" determination. (121a)

Moreover, physicians disagree as to the gestational age at which viability occurs. Drs. John Franklin and Louis Gerstley, both Board-certified obstetricians and gynecologists, testified upon behalf of Appellees. Dr. Franklin placed viability at about 28 weeks (20a), based upon a 10% chance of survival at that time. (180a) However, he noted that other physicians, particularly neonatologists, who specialize in caring for immature fetuses (31a), might consider a 21-week fetus viable. (29a)

Although Dr. Franklin has sent immature fetuses to a neonatologist, to his knowledge, none have survived. (34a) He theorized that attempts to prolong life at the 20-to-30-week gestational area might result in "artificial viability". (21a)

Dr. Gerstley had a different interpretation of the statutory language. He thought a 24-week fetus had a "reasonable chance of survival", which he defined as somewhere between two and five percent. (8a-9a) He further noted that it is increasingly difficult to determine gestational age as the stage of pregnancy advances. (10a)

Both Drs. Franklin and Gerstley feared that their determination of non-viability might be challenged in a subsequent criminal prosecution. (29a; 30a-31a; 16a) As Dr. Gerstley put it, the statutory language

> "leaves the interpretation of 'viability' up to whoever is interpreting the term 'viability' . . . be that the physician or the prosecuting district attorney . . . [and] if a district attorney wanted to make a case, he could say that the physician's judgment is not valid." (16a)

Dr. Franklin further noted that the possibility of other physicians testifying in a criminal prosecution that a 21-week fetus was viable would inhibit his conduct. (29a)

Physicians who testified as to the meaning of viability upon behalf of Appellants disagreed with each other as well as with Appellees' witnesses. Dr. William J. Keenan testified that a 28-week fetus would have a 50 to 60% chance of survival. (92a-93a) He placed viability at 26 weeks, based upon a 10 to 30% chance of survival at that time. He thought that a 20 to 26-week fetus "might be viable". (104a-105a)

However, Dr. Keenan defined viability as survival for 28 days after birth. (108a) He did not testify with reference to the statutory definition.

Citing a report in an early edition of an obstetrics textbook, Dr. Fred Mecklenburg testified that a 20-week fetus was viable. (45a) However, Dr. Keenan challenged that testimony as "not reasonable" and stated that "[e]verybody mistrusts that information." (118a)

Although Dr. Thomas W. Hilgers thought that he could make a reasonable determination that a four-and-a-half to five-month old fetus, weighing more than 400 grams, was viable (79a), he emphasized that it was "very difficult" to determine the size of an unborn infant. (80a) Moreover, he stated that it was impossible to determine viability before birth. (77a)

Witnesses for both sides acknowledged that there is a two to four-week margin of error in estimating gestational age (R. 31; 111a-112a), which compounds the uncertainty of determining whether a fetus is viable or may be viable.

The vagueness of the statutory language causes a particular hardship on couples who are carriers of some sixty genetic diseases. Dr. Hope Punnett, an expert on genetic counseling and testing, testified that amniocentesis can be performed during pregnancy to determine whether a fetus is affected with a grave genetic abnormality such as Tay Sachs or Down's Syndrome (Mongolism). (49a-50a) Children affected with Tay Sachs begin deteriorating at six months. By the age of three, they have lost all function and must be institutionalized until their death at the age of seven or eight. (50a)

However, the test cannot be initiated until 16-weeks' gestation (53a), and the results may not be conclusive until late in the second trimester, beyond 20-weeks' gestation. (53a-54a) A 20-week cut-off for abortions would make genetic counseling "very, very difficult", (55a) since

> "[o]ne cannot guarantee a family that we will have a result by a magic date. Sometimes this takes six weeks to get an answer. One cannot do genetic counseling if you cannot follow it to a logical conclusion". (55a)

Dr. Punnett believed that, if no answer were available at 20 weeks, the family might then abort what would have been a normal and wanted child. (55a)

On the issue of abortion methods, there was no medical consensus as to which technique

> "would provide the best opportunity for the fetus to be aborted alive." § 5(a)

Dr. Hilgers testified that the best method of preserving fetal life and health was to keep the fetus in the

mother's womb. (75a; 82a) He noted that 15 to 17% of premature infants are affected by motor and mental retardation (73a-75a); and that it would, therefore, be a "great disservice" to deliberately deliver an infant prematurely. (82a)

If a late abortion were to be performed, Dr. Hilgers suggested using prostaglandins. (80a-81a) However, that technique was relatively new at the time of the hearing in the court below. None of the physicians stated that they had ever used it; and Drs. Hilgers, Franklin and Gerstley stated that they had not. (72a; 27a; 83a-84a) Moreover, Dr. Gerstley noted that prostaglandins causes side effects (11a) such as nausea, vomiting, headaches and diarrhea. (38a) In addition, repeated injections are frequently required. (11a)

Although Dr. Gerstley preferred saline for late abortions (11a), saline is unlikely to result in a live birth. (12a) If forced to deliver a 26-week fetus alive, he would use oxytosin induction. (12a) However, forcing oxytosin to work at that stage would be a prolonged and expensive procedure for the woman. (12a) Dr. Franklin confirmed that oxytosin was difficult and might take several days. (27a)

Dr. Mecklenburg thought that the statute required a hysterotomy, which is similar to a Caesarian section. (40a) However, Dr. Hilgers testified that hysterotomies have the highest mortality rate of all the procedures. (73a) Infection and hemorrhage occur in 35 to 45% of the cases. (73a) Although Dr. Franklin did not think that hysterotomies were life-threatening to the woman, he acknowledged that he had never performed any. (29a)

Dr. Gerstley pointed out that, once a hysterotomy has been performed, all future children may have to be delivered by Caesarian section. (13a)

SUMMARY OF ARGUMENT.

In accordance with *Roe v. Wade*, 410 U. S. 113 (1973), a state may not regulate the abortion decision in the interest of fetal life prior to viability. By imposing a standard of care toward the fetus during the period of "potential viability", section 5(a) unconstitutionally restricts the woman's fundamental right to terminate her pregnancy prior to viability without regard to the state's interest in fetal life.

Furthermore, section 5(a) fails to adequately inform a physician when his duty toward the fetus arises. The physician risks criminal penalties if he aborts a "may be viable" fetus and fails to use the abortion technique which would be most likely to result in a live birth. However, the statute does not specify when a fetus "may be viable" or which abortion technique would satisfy the statutory standard. Disagreement among physicians as to the time of potential viability and the abortion method required demonstrates the vagueness of the statutory language.

Moreover, the physician's good faith determination is not conclusive. Since the physician cannot know, prior to performing an abortion, whether a fetus is viable and whether his judgment that it is not will be challenged in a subsequent criminal prosecution, he will understandably choose to err on the side of caution and refuse to perform an abortion whenever he has some question as to whether a particular fetus may be viable. As a result, women will be deprived of their fundamental right to terminate their pregnancy late in the second trimester.

For example, couples affected by certain genetic conditions may be deprived of the right to conceive and bear their own biological children. Although amniocentesis can be done to determine if a fetus is affected with a serious

and fatal genetic disease, the test results may not be known until late in the second trimester. At that point, a physician might refuse to take the risk that the fetus is not viable and, therefore, refuse to perform the abortion.

ARGUMENT.

I. Section 5(a) Unconstitutionally Restricts the Abortion Decision in the Interest of Fetal Life Prior to Viability; the Provision Is Overbroad.

Statutes which restrict the exercise of fundamental rights must be narrowly drawn to meet a compelling state interest. *Roe v. Wade,* 410 U. S. 113 (1973); *Doe v. Bolton,* 410 U. S. 179 (1973); *Griswold v. Connecticut,* 381 U. S. 479, 485 (1965); *NAACP v. Alabama,* 377 U. S. 288, 307 (1964). The legislation must be "necessary and not merely rationally related to the accomplishment of a permissible state policy." *McLaughlin v. Florida,* 379 U. S. 184, 196 (1964).

Roe v. Wade, 410 U. S. 113, 153, 155 (1973) established that the fundamental right of personal privacy is "broad enough to cover the abortion decision." As Mr. Justice Blackmun recognized:

> "The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon a woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise to care for it. In other cases . . . the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation." 410 U. S. at 153.

Since the pregnant woman has a fundamental right to terminate her pregnancy, the State may not limit her decision absent a *compelling* State interest.

In *Roe*, the Supreme Court recognized that the State has legitimate interests in maternal health and in protecting the potentiality of human life. Each of those interests becomes compelling at some point during the pregnancy; but, until that point is reached, the State may not, in furtherance of its interests in maternal health or fetal life, unduly restrict the woman's decision to abort,

> "the abortion decision in all its aspects is inherently and primarily, a medical decision, and basic responsibility for it must rest with the physician. *Roe v. Wade, supra,* at 166.

Restrictions which impinge upon the physician's medical judgment prior to the inception of a "compelling" state interest, violate both the pregnant woman's fundamental right to determine, in consultation with her attending physician, whether to obtain an abortion and the attending physician's right to freely practice the profession of his choice. *Roe v. Wade, supra; Young Women's Christian Association of Princeton, N. J. v. Kugler,* 342 F. Supp. 1048 (D. N. J. 1972; 3-judge court), *vacated and remanded,* 475 F. 2d 1398, *aff'd.,* 493 F. 2d 1402 (3rd Cir.), *cert. denied,* 415 U. S. 989 (1974). Consequently, such restrictions have been stricken. See, *e.g., Doe v. Mundy,* 378 F. Supp. 731 (E. D. Wisc. 1974), *stay denied,* 419 U. S. 813, *aff'd.,* 514 F. 2d 1179 (7th Cir. 1975) (hospital may not prohibit performance of elective abortions); *Hodgson v. Anderson,* 378 F. Supp. 1008 (D. Minn. 1974; 3-judge court), *appeal dismissed sub nom. Spannus v. Hodgson,* 420 U. S. 903 (1975) (rules and regulations for abortion and abortion facilities); *Nyberg v. City of Virginia,* 495 F. 2d 1342 (8th Cir.), *appeal dismissed,* 419 U. S. 891 (1974) (hospital must make its facilities available for performance of abortions); *Doe v. Rampton,* 366 F. Supp. 189 (D. Utah; 3-judge court), *vacated and remanded,* 410 U. S. 950 (1973) (medical reasons for abortion; concurrence of two consulting physicians; spousal and parental consent; judicial hearing).

The State's interest in potential life is not "compelling" until "viability". *Roe v. Wade, supra,* at 163. Viability is described as the point at which the fetus is

> "potentially able to live outside the mother's womb, albeit with artificial aid,"

which

> "is usually placed at about seven months (28 weeks) but may occur earlier even at 24 weeks." [5] *Roe v. Wade, supra,* at 160.

Section 5(a) of the Pennsylvania Abortion Control Act ——in disregard of this Court's dictates in *Roe v. Wade* —— seeks to regulate in the interest of fetal life prior to viability by imposing a duty of care toward a "may be viable" fetus. Accordingly, Section 5(a) is overbroad, and the decision of the three-judge court below invalidating that provision, (184a, 238a), should be affirmed.

As Judge Green reasoned in the Opinion below:

> "*Roe* recognizes only two periods concerning fetuses. The period prior to viability when the state may not regulate in the interest of fetal life, and the period

5. The latest edition of the medical text cited by the Court as authority for its description of "viability" no longer defines viability as 28 weeks' gestation. The authors note that viability is difficult to define. J. Pritchard and P. McDonald, *Williams Obstetrics,* 483 (15th ed. 1976).

after viability, when it may prohibit altogether or regulate as it sees fit. The 'may be viable' provision of Section 5(a) tends to carve out a third period of time of potential viability. Defendants' witness, Dr. Keenan, testified that based upon his interpretation of Act 209, the Act's definition of potential viability occurs at 20 to 26 weeks gestation. (See Tr. 1/17/75, p. 549.) It is clear that in carving out this new time period labelled 'may be viable' the state is regulating abortions during the second trimester, when it may lawfully do so only in the interest of maternal health . . . [T]he State seeks to justify this provision only as a measure in furtherance of its claimed interest in protecting potentially viable fetuses. Since this provision does not meet the requirements of *Roe*, we declare it to be unconstitutional." (184a)

Your Honorable Court recently reaffirmed the holding in *Roe v. Wade, supra,* in a decision which is directly on point to the present case. In *Planned Parenthood of Cent. Mo. v. Danforth,* 428 U. S. 52 (1976), the Court held unconstitutional a Missouri statute which, like Section 5(a) of the Pennsylvania statute, imposed a standard of care toward the fetus prior to viability. That the Missouri duty of care applied during all stages of pregnancy, whereas the Pennsylvania law applies only after the fetus "may be viable" is a distinction without a difference. (See Brief for Appellants, at p. 18, n. 15). The Missouri statute was held unconstitutional because it restricted, in the interest of fetal life, a woman's decision to terminate her pregnancy prior to viability. Since the Pennsylvania provision also seeks to regulate in the interest of fetal life before that interest has become "compelling", it is likewise unconstitutional.

Other courts, considering similar statutes, have agreed. For example, in *Hodgson v. Lawson,* 542 F. 2d 1350 (8th Cir. 1976), the court invalidated as unconstitutionally overbroad a Minnesota statute which prohibited abortion when the fetus was "potentially viable," unless the abortion was necessary to preserve the woman's life or health.

Wynn v. Scott, No. 75 C-3975 (E. D. Ill., April 12, 1978), cited by Appellants (at p. 18), does not suggest a contrary result. Unlike the Pennsylvania statute, the duty of care in the Illinois statute was limited to viable fetuses.

Clearly, Section 5(a) is not narrowly drawn to meet a compelling state interest.

By prescribing a duty of care toward a "may be viable" fetus, Section 5(a) "sweep[s] unnecessarily broadly and thereby invade[s] the area of protected freedoms." *Griswold v. Connecticut, supra,* at 485, quoting *NAACP v. Alabama,* 377 U. S. 288, 307. As the three-judge court below recognized, the provision is unconstitutional.

II. Section 5(a) Is Void for Vagueness.

A. The Terminology "May Be Viable" Fails to Inform the Physician When His Duty Toward the Fetus Arises.

The Due Process Clause of the Fourteenth Amendment requires a state to frame its criminal statutes so that persons may know what conduct is required. *Cline v. Frink Dairy Company,* 274 U. S. 445, 458 (1927). Statutes which fail to provide fair warning to potential offenders or do not set standards to guide courts and juries in determining whether a crime has been committed, violate the due process clause and are void-for-vagueness. Note, "The Void-for-Vagueness Doctrine in the Supreme Court," 109 *U. Pa. L. Rev.* 67, 68 n. 3 (1960).

As the Supreme Court has stated:

> ". . . [A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law." *Connally v. General Const. Company,* 269 U. S. 385, 391 (1926).

See also, *Winters v. New York,* 333 U. S. 507, 515, 518, 520 (1948); *Lanzetta v. New Jersey,* 306 U. S. 451, 453 (1939); *Champlin Ref. Co. v. Commission,* 286 U. S. 210, 242-243 (1932).

Legislation which limits fundamental rights is held to an especially high degree of certainty, lest the imprecision of the statutory language impermissibly "chill" the exercise of those fundamental rights. *Grayned v. City of Rockford,* 408 U. S. 104, 108-109 (1972).

As Mr. Chief Justice Burger stated in his concurring opinion in *Roe v. Wade,* 410 U. S. 113, 208 (1973):

> "Of course, states must have broad power, within the limits indicated in the opinions, to regulate the subject of abortions, but where the consequences of state intervention are so severe, uncertainty must be avoided as much as possible."

By imposing a duty of care toward a "may be viable" fetus, Section 5(a) of the Abortion Control Act fails to satisfy this requirement of certainty. Section 5(a), as enforced by Section 5(d)[6], puts a physician in jeopardy

6. Section 5(a) provides as follows:

"Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or *if there is sufficient reason to believe that the fetus may be viable,* shall exercise that degree of professional skill, care and

of criminal sanctions for performing an abortion whenever a fetus "may be viable". From that time of potential viability onward, the physician must use the abortion method most likely to result in a live birth, unless a different method is necessary to preserve the life or health of the pregnant woman.

However, the statute fails to inform the physician when this duty toward the fetus arises. The statute does not specify when potential viability occurs,[7] and there is considerable medical disagreement on that question. (8a-11a; 20a-21a; 30a-33a; 45a; 81a; 92a-93a; 104a-105a; 108a-109a; 116a-118a; 120a; 128a; 129a; 134a; 138a-139a; 143a-144a; 151a-152a)

Interpretations at the hearing in the court below ranged from 28 weeks down to 20 weeks. Dr. Franklin

6. (Cont'd.)
diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother." [Emphasis added.]

Section 5(d) provides, in pertinent part, as follows:

"Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section . . . shall be subject to civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted."

7. Since the Court did not consider the time frame for "possible viability" in *Planned Parenthood of Cent. Mo. v. Danforth,* 428 U. S. 52 (1976), the comments concerning the legislative definition of viability in that case (see Brief for Appellants at p. 28), do not apply to the vagueness problem in the present case. Section 2 of the Act defines "viability" as having the "capability . . . to live outside the mother's womb albeit with artificial aid". The Act contains no definition of "may be viable."

placed viability at 28 weeks' gestation (20a), based upon a 10% chance of survival at that point. (180a) However, he recognized that other physicians, particularly neonatologists, who specialize in the care of immature fetuses (31a), might consider a 21-week fetus viable. (29a)

Dr. Franklin noted that he has sent immature fetuses to a neonatologist, but, to his knowledge, none have survived. (34a) Attempts to prolong life in the 20-to-30-week gestational period might result in "artificial viability". (21a)

Dr. Gerstley interpreted viability differently. He testified that a 24-week fetus would have a "reasonable chance of survival," on the order of two to five percent. (8a-9a) He noted that the farther along the pregnancy, the harder it is to determine gestational age. (10a)

Dr. Keenan placed viability at 26 weeks, based upon a 10 to 30% chance of survival at that time. (102a) He stated that a 28-week fetus would have a 50-60% chance of survival. (92a-93a) He thought that a 20 to 26-week fetus "may be viable". (104a-105a)

However, Dr. Keenan did not testify with reference to the statutory definition of viability. He defined viability as survival for 28 days after birth. (108a)

Dr. Mecklenburg thought that a 20-week fetus was viable (45a), but Dr. Keenan challenged the data upon which Dr. Mecklenburg relied as "not reasonable" (118a) and not in accordance with current technology. (117a)

While Dr. Hilgers thought he could make a reasonable determination that a four-and-a-half to five-month old fetus, weighing more than 400 grams, was viable (79a), he also thought that it was very difficult to determine the size of an unborn infant. (80a)

Furthermore, all physicians unanimously testified in the court below that it is impossible to determine with

certainty whether a particular fetus is viable while it is still in the womb well into pregnancy. (6a-7a; 19a; 43a-44a; 77a-80a; 93a-101a; 111a-112a; 120a-123a; 137a-138a; 141a-142a) Appellants concede this impossibility. (Brief for Appellants, at p. 26). The most that can be done is to suggest some probability of survival by estimating the period of gestation and applying data relating to survival of fetuses of comparable maturity. (5a-8a; 14a; 19a-21a; 93a-102a)

Among the factors which are considered—none of which can be accurately pinpointed—are the gestational age and the size and weight of the fetus. These factors are "guesstimate[d]" (79a) by the pregnant woman's often inaccurate report of her menstrual history (96a-97a) and an external examination. (94a) Other factors include maternal health and nutrition, which affect both size and probability for survival; race; sex; and the neonatology facilities available in a particular hospital. (78a; 101a; 111a-112a)

There is a two to four week margin of error in estimating gestational age because of the imprecise methods which must be used. (R. 31; 111a-112a)

Despite the impossibility of accurately and objectively determining potential viability prior to an abortion, Section 5(d) imposes criminal sanctions upon a physician who fails to make that determination. Willful or wanton misconduct or even bad faith are not prerequisites to criminal liability. Therefore, even where a physician has determined *in good faith* [8] that a fetus is not viable and has aborted it, there is a very real possibility that the courts will, nevertheless, hold him criminally liable for aborting what other doctors will testify was a viable fetus. (183a)

8. It is undisputed that a physician may not act in bad faith in determining that a fetus is not viable. Appellants' contrary assertion at page 32 of their Brief is unsupportable.

See also, Mr. Justice Douglas dissenting in *United States v. Vuitch*, 402 U. S. 62, 74-75 (1971), on the grounds that the statute did not provide that the physician's determination was conclusive.

Drs. Franklin and Gerstley both expressed their fear of being second-guessed by a court or jury. Reputable physicians, especially neonatologists, might consider a 21-week fetus viable and so testify in a criminal proceeding against another physician. (29a; 30a-31a)

As Dr. Gerstley noted, the statutory language

> "leaves the interpretation of 'viability' up to whoever is interpreting the term 'viability' . . . be that the physician or the prosecuting district attorney . . . [and] if a district attorney wanted to make a case, he could say that the physician's judgment is not valid." (16a)

Inevitably, the fear of being second-guessed will inhibit physicians from performing lawful abortions. As a result, women may be deprived of their fundamental right to terminate their pregnancy during the second trimester without regard to the potential for fetal life. (183a); *Roe v. Wade*, 410 U. S. 113 (1973). As Judge Muir stated in invalidating the definition of viability in the same statute which is the subject of the present case:

> "A doctor contemplating the performance of an abortion and faced with the definition of 'viability' contained in § 2 is, prior to the operation, unable to determine with assurance whether he will be subject to prosecution if he operates . . . [H]e faces the possibility that there will be a challenge in a later criminal proceeding to the manner in which he made the assessment of non-viability prior to the performance of the abortion. Consequently, *the uncertainty introduced by § 2 is likely to lead to a severe curtailment of permissible abortions because of the fear of criminal prosecutions engendered in doctors who are requested to perform them. Doe v. Zimmerman*, 405 F. Supp. 534, 539 (M. D. Pa. 1975; 3-judge court). (Emphasis added).

Furthermore, the statute provides no standards to guide a court or jury in determining whether a crime has been committed. Consequently, it subjects physicians to the danger of arbitrary and discriminatory prosecution. Such dangers will also inhibit physicians from performing second-trimester abortions. As the three-judge court below recognized:

> ". . . without an objective standard to guide law enforcement officers, prosecutors and courts, physicians will be subject to prosecution controlled only by the subjective determinations of those charged with law enforcement. The possibility of such arbitrary enforcement certainly will . . . inhibit and deter physicians from performing abortions after a fetus has reached the gestational age of 20 weeks." (183a)

Contrary to Appellants' contentions, the statutory language is not "clear and concise and capable of interpretation by the medical community". (Brief for Appellants, at p. 28)[9]. Nor is it similar to the determination of

9. "May be viable" are "terms involving an appeal to judgment or a question of degree," E. Freund, "The Use of Indefinite Terms in Statutes," 30 *Yale L. J.* 437 (1921), and not "abstractions of common certainty," as Appellants allege at page 29 of their Brief. As Professor Freund recognized, the choice of terms involving an appeal to judgment or a question of degree, the least precise grade of certainty, is more an expression of an inability to deal with a problem than a matter of policy. *Id.*, at 438.

Furthermore, the alleged need for "flexibility of the term," (Brief for Appellants, at p. 26), does not absolve the state of its duty to frame its criminal statutes with precision.

whether an abortion is "necessary for the preservation of the mother's life or health," upheld in *United States v. Vuitch*, 402 U. S. 62, 72 (1971).

A doctor is routinely required, outside the abortion context, to make judgments about his patients' health; and he has numerous objective tests, such as blood tests, x-rays, and EKGs to assist him in making that determination. Only in the abortion context, however, is he subject to criminal liability for his determination of non-viability, a judgment he must make in the absence of any scientific or direct tests.[10]

Clearly, Appellants' contention that "[t]he vagueness argument is set at rest by the decision in *United States v. Vuitch*, 402 U. S. 62, 71-72," (Brief for Appellants at p. 31), is erroneous.

As the three-judge court below held, Section 5(a), as enforced by Section 5(d), is void-for-vagueness.

B. The Statute Fails to Afford Physicians Discretion in Determining Which Abortion Technique Is Appropriate.

Section 5(a) also fails to adequately inform a physician which abortion method he must use during the late second or third trimester in order to avoid criminal liability.[11] The statute directs him to use that technique which

> "would provide the best opportunity for the fetus to be aborted alive, so long as a different technique would not be necessary in order to preserve the life or health of the mother."

10. Amniocentesis can be used to determine the lecitthinsphynogomyelin ratio, but this ratio does not usually determine viability until about the 34th or 36th week of pregnancy. (7a)

11. Insofar as this requirement applies to the "may be viable" fetus, it impermissibly restricts the abortion decision in the interest of fetal life before that interest has become "compelling." Accordingly, it is unconstitutionally overbroad. See Section I, *supra*.

Among the methods commonly used for late abortions are saline, prostaglandins, oxytosin induction and hysterotomy.[12] Since saline almost always kills the fetus in utero (36a), Section 5(a) in effect bans the use of saline whenever the fetus is or may be viable, unless that method is necessary to preserve the woman's life or health.

However, as the opinions in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U. S. 52 (1976) and *Wynn v. Scott*, No. 75 C 3975 (N. D. Ill. April 12, 1978; 3-judge court) recognized, the injection of saline is the method of choice in late abortions. It is safe and effective where the technique is standardized and carried out in a well-equipped institution. D. Sherman, "Salting Out: Experience in 9000 Cases," *J. Reprod. Med.* 14:24 (June 1975; cited by Appellants at page 23).

12. Physicians disagree as to the advisability of dilation and extraction (D&E) for second trimester abortions. Planned Parenthood Federation of America has recognized that this technique is safe for the woman when performed by a skilled physician. Accordingly, Section VII-A of the Manual of Medical Standards and Guidelines prepared by the National Medical Committee of Planned Parenthood Federation of America was revised on or about March 27, 1978, to provide, in pertinent part, as follows:

> "Where there are personnel experienced in performing second trimester abortions and adequate facilities and equipment, Planned Parenthood Affiliates may perform abortions up to 16 weeks from the last normal period [14 weeks from conception] by dilatation and evacuation . . . ."

However, some physicians do not favor D&Es after 12 weeks' gestation, because of the danger of perforating the uterus. (39a) The following articles cited by Appellants and written by non-physicians who advocate the use of D&Es as less psychologically traumatic for the woman demonstrate the differences of opinion: "MDs Shun 16th Week D&E as Reminder of Destroyed Fetus," *Medical Tribune*, 9 (January 25, 1978); J. Rooks and W. Cates, Jr., "Emotional Impact of D&E vs. Instillation," *Family Planning Perspectives* 9:276 (Nov.-Dec. 1977).

While any medical procedure is not without complications, Appellants imply that the use of saline presents a medical danger to the woman.[13] For example, at page 23 of their Brief, Appellants cite T. Wagatsuma, "Intra-amniotic Injection of Saline for Therapeutic Abortion," *Am. J. Obst. & Gynec.* 93:743 (November 1, 1965). That article reported on the use of saline in post-war Japan. It emphasized the disastrous and chaotic social conditions in Japan at that time, and the procedures under which saline was used. In many cases, saline was administered by non-specialists under inadequate conditions.[14] Significantly, the Japanese used a 35% saline concentration, whereas a 20% concentration is presently used in the United States. The authorities cited by Appellants in their own Brief state that this difference in saline concentration may have been significant.[15]

Despite the relative safety of saline, Section 5(a) in effect prohibits the physician from using saline under most circumstances.[16] He is left, therefore, with a choice between hysterotomy, prostaglandins or oxytosin induction.

Physicians disagree as to which method would satisfy the statutory requirement. Interpretations at the hearing

13. See S. Lemkin and H. Kattlove, "Maternal Death Due to DIC After Saline Abortion," *Obstet. and Gyn.* 42:233 (August, 1973), cited by Appellants at page 24 of their Brief, reporting what the authors believed was the "only recorded maternal death due to DIC occurring in the course of saline amnioinfusion." *Id.*, at 235.

14. The author believed that most maternal deaths could have been prevented if the procedure had been used by experienced spcialists in well equipped institutions, on patients whose general condition had been evaluated carefully.

15. See J. Greenhalf and P. Diggory, "Induction of Therapeutic Abortion by Intra-amniotic Injection of Urea," *Brit. Med. J.* 1:28 (1971), cited by Appellants at page 23 of their Brief.

16. Since saline rarely produces a live birth, it may be used only when necessary to preserve the life and health of the woman.

below ranged from no abortion (75a; 82a), to prostaglandins (80a-81a; 37a), hysterotomy (22a-23a; 26a-29a), or oxytosin induction. (12a) Dr. Hilgers testified that the best method of preserving fetal life and health is to keep the fetus in the mother's womb. (75a; 82a) Premature birth is one of the leading causes of mental and motor retardation. (73a-75a; 81a-82a; 129a) Even if 20-week fetuses were able to survive,[17] approximately 15 to 17% would suffer from mental or motor retardation. (75a) Therefore, any abortion method designed to produce a live birth would, in effect, amount to the intentional infliction of prenatal injury. As Dr. Hilgers stated:

> If I am going to risk the premature birth of a child, I am doing a great disservice to that child, and I would not perform this [abortion] procedure as a result of that." (82a)

Nevertheless, when pressed to select an abortion method, Dr. Hilgers chose prostaglandins. (80a-81a) However, at the time of the hearing, none of the physicians who testified stated that they had ever used prostaglandins, and Drs. Hilgers, Franklin and Gerstley stated that they had not. (72a; 27a; 83a-84a) Dr. Gerstley noted his dissatisfaction with prostaglandins because of the side effects it causes. (11a) Among those side effects are nausea, vomiting, headaches and diarrhea. (38a) In addition, prostaglandins are more likely than saline to require repeated injections. (11a) See also, World Health Organization Task Force, "Prostaglandins and Abortions,"

17. Dr. Hilgers identified the survival rate at that age as 20 to 21%. (81a) Dr. Keenan testified that 20-week fetuses do not survive. (91a)

Dr. Franklin testified that any attempts to prolong life in the 20-to-30 week gestational area would in fact merely prolong death. (21a)

Am. J. Obstet. Gynecol. 129:597, 599 (November 15, 1977), cited by Appellants at page 22 of their Brief,[18] reporting a "disappointing" although "encouraging" success rate. Abortions were complete in only 31.7% of the 660 patients included in that study. *Id.*, at 598.

Moreover, prostaglandins are medically unsafe for some women. Prostaglandins should not be used on women who have acute pelvic inflammatory disease or are hypersensitive to the drug. It must be used only with caution in patients with a history of asthma, glaucoma, hypertension, cardiovascular disease, or a past history of epilepsy. *Wynn v. Scott, supra,* at 63-64, quoting the description of prostaglandins prepared by the Upjohn Company, which distributes the drug, and approved by the Food and Drug Administration.

For these women, the only remaining methods are oxytosin induction or hysterotomy. Dr. Gerstley recommended oxytosin induction. (12a) However, he doubted whether the procedure would be effective and noted that forcing it to work at that stage would be prolonged and expensive for the patient. (12a) Dr. Franklin confirmed that oxytosin induction was difficult and might take several days, although he stated that he had never used it. (27a)

According to Appellants, hysterotomy is the preferred procedure for inducing live births. (Brief for Appellants, at p. 22). However, Appellants' own witness Dr. Hilgers testified that hysterotomies have the highest mortality rate of all the procedures. (73a)[19] Infection and hemorrhage occur in 35 to 45% of the cases. (73a) Moreover, all future children born to that woman would

18. This article was inadvertently cited in Appellants' Brief as appearing in volume 192.

19. Dr. Franklin's testimony that the risks to the mother's health are not great (29a) merely demonstrates the medical disagreement as to the appropriate abortion technique.

probably have to undergo Caesarian section, because of the danger of rupture of the scar. (13a) Indeed, the Courts in both *Planned Parenthood Association of Central Missouri v. Danforth, supra,* at 76, 79, and *Wynn v. Scott, supra,* at 59-60, concluded that hysterotomy had a significantly greater risk of complications than the other abortion methods and was not, therefore, an adequate substitute for saline amnioinfusion.

Despite the medical disagreement as to which technique "would provide the best opportunity for the fetus to be aborted alive" (§ 5(a)), the statute does not suggest any methods, and there is no assurance that the physician's good faith determination will not be challenged in a subsequent criminal prosecution. (32a-33a) Appellants' contention at page 25 of their Brief that the existence of alternatives and the physician's good faith medical judgment are the only legally relevant considerations cannot save the unconstitutional vagueness of the statutory language. Appellants' interpretation would not be binding upon the district attorneys who may prosecute physicians or the courts and juries which may convict them. It is no substitute for a clear legislative description or a binding judicial interpretation.

Accordingly, the requirement that, whenever the fetus "may be viable", the physician must use the abortion technique "which would provide the best opportunity for the fetus to be aborted alive", violates the Due Process Clause of the Fourteenth Amendment and is void-for-vagueness.

III. Section 5(a) Unconstitutionally Restricts a Couple's Right to Conceive and Bear Their Own Biological Children.

As already discussed, the vagueness and overbreadth of Section 5(a) unconstitutionally "chill" the pregnant

woman's fundamental right, in consultation with her physician, to terminate her pregnancy during the latter part of the second trimester. As the record in the court below demonstrated, this provision will seriously undermine the opportunity of families with certain genetic characteristics to conceive and bear their own biological children and, in some cases, will result in the abortion of normal and wanted children.

Dr. Hope Punnett, an expert on genetic testing and counseling, testified that where couples have been identified as carriers of some sixty genetic disorders (58a), a test, called amniocentesis, can be performed during pregnancy to determine whether the fetus is affected by the genetic abnormality. If the test results are positive, the fetus may be aborted, thereby saving the parents and the child from the "awful agony of a slow and painful death." (50a)

Amniocentesis requires culturing of cells taken from the amniotic fluid. (50a) The test cannot be initiated with any degree of success prior to the 16th week of gestation, since the uterus is not large enough until that time.[20] If the culture is successful, it takes two to six weeks to be concluded. (53a)

Occasionally, the cells do not grow, but that is not known for a week or ten days. At that point, the obste-

20. Appellants' contention at page 37 of their Brief that "testing for genetic defects or diseases is for the most part completed *prior* to the attainment of viability by the fetus," (emphasis in original), is erroneous. As Dr. Punnett testified in the court below, it is not feasible to begin amniocentesis until 16-weeks' gestation. (53a) Taps begun at 13 weeks are not successful and must be repeated. (63a-64a) N. Simpson, *et al.*, "Prenatal Diagnosis of Genetic Disease in Canada: Report of a Collaborative Study, *CMA Journal* 115:739 (1976), cited by Appellants at page 39 of their Brief, confirms that success in obtaining amniotic fluid is directly proportional to gestational age, and that the procedure is safe, accurate and reliable when carried out at 16 weeks' gestation.

trician would have to do a second embryotic tap and hope that the cells would then grow. Consequently, positive results could not be obtained until 18 to 20 weeks' gestation at the earliest. (53a)

Tay-Sachs disease and Down's Syndrome (Mongolism) are two of the genetic disorders which can be diagnosed prenatally. Children affected with Tay-Sachs appear normal at birth, but begin deteriorating within six months. By the age of three, they have lost all function and require custodial care until their death at the age of seven or eight. (50a)

Approximately one in every 15 Jews of Eastern European descent is a carrier of Tay-Sachs. The disease is seen in other populations, but it is rarer. (57a) Carriers can be identified by a simple bloodtest.[21] Where a couple are both carriers, there is a 25% chance that each pregnancy will involve Tay-Sachs. (51a)

Genetic counseling provides several options to couples identified as carriers. The couple may (1) proceed with conception without regard to the consequences to the child; (2) prevent conception entirely; (3) accept artificial insemination from a non-carrier donor; or (4) monitor the pregnancy and abort an affected fetus. (51a-52a) Only the latter enables the couple to bear their own biological children without risk.

However, Section 5(a) could prevent a couple from exercising that option. As already mentioned, the results of the amniocentesis may not be known until late in the second trimester, possibly later than 20-weeks' gestation.[22]

21. In the case of Down's syndrome, the propensity for the disease is usually not identified until the birth of the first defective child. Women over the age of 38 have a high risk of having children affected with Down's Syndrome. (50a)

22. Inasmuch as Dr. Punnett is associated with a hospital which does not perform abortions (54a) and which does a very

Faced with a statute which imposes criminal liability upon a physician who aborts a fetus which "may be viable", and armed with the knowledge that physicians disagree as to the point of viability and that the woman's report of her gestational period is very likely inaccurate (96a-97a), a physician may understandably refuse to carry genetic counseling through to its logical conclusion.[23]

Where the test was not conclusive until late in the second trimester of pregnancy,[24] the couple would be deprived of the benefits of the test results which could be obtained and forced to wait out the pregnancy, not knowing whether the child may be "doomed to death" (50a) at a very early age, or abort what may have been a normal and wanted baby. (55a)

Such a result impermissibly infringes upon the fundamental right to bear one's own biological children. *Skinner v. Oklahoma*, 316 U. S. 535, 541-542 (1942). As the three-judge court below concluded, Section 5a is unconstitutional. (177a-185a; 238a)

Appellants' contention at page 42 of their Brief that the decision of the court below is a

> "step down the path of genetic or social selections formerly trod by the ancient Spartans, who . . . laid

22. (Cont'd.)

small number of screenings for Tay-Sachs (57a), her personal observation of only one abortion beyond 20 weeks' gestation does not indicate that such cases are rare, as Appellants seem to imply at page 38, n. 13 of their Brief. (55a)

23. The statute prohibits abortions after viability unless necessary to preserve the woman's life or health. The vagueness of the statutory definition and the potential for criminal sanctions would cause the physician to err on the side of caution and refuse to perform an abortion late in the second trimester of pregnancy.

24. Availability of the test results at that time—which may be the earliest they are obtainable—would be of no avail, unless the doctor determined that the pregnancy endangered the woman's life or health.

> the weakest new-born infants on the hillsides of Sparta to die,"

is unsupportable.[25] No one is suggesting that a physician, or anyone else, has any right to destroy a live born child. What we do contend, however, is that before potential life has developed into actual life, the woman, in consultation with her physician, has a constitutional right to decide whether to terminate her pregnancy, and that in making that determination, she is entitled to know whether the fetus is affected with a serious and fatal genetic disease.

Indeed, both the American Medical Association and the American College of Obstetricians and Gynecologists have approved resolutions favoring abortion where

> "[t]here is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency." AMA Resolution of June 1967, quoted in C. Kindregan, "Eugenic Abortion," *Suffolk U. L. Rev.*, 3:406, 425 (1972).

See also, Amer. Coll. of Ob. and Gyn., Rptr. H. R. L. § I-A-2, quoted in C. Kindregan, *supra.*

The Model Penal Code has also adopted that position. Model Penal Code § 230.3(2) (Master Edition 1974).

In addition, at least one court has ruled that

> ". . . [T]he state has less interest in the birth of such a child [with a serious genetic disease] than a woman has in terminating such a pregnancy,"

25. Equally unsupportable is Appellant's reference at page 42, n. 18, to the psychological impact upon handicapped persons. Section 6(d) directs the physician to use his judgment in making the determination that an abortion is necessary. Appellants unjustifiably denigrate that judgment by implying that the physician would not restrict such therapeutic abortions to cases where the fetus is affected with a grave, incapacitating and fatal genetic disease.

and that

> "for the state to deny therapeutic abortion in these cases is an overreaching of the police power." *Abele v. Markle,* 342 F. Supp. 800, 804 (D. Conn. 1972; 3-judge court), *vacated,* 410 U. S. 951 (1973), *reh. denied,* 411 U. S. 940, *on remand,* 369 F. Supp. 807 (D. Conn. 1973; 3-judge court).[26]

See also, *Doe v. Bolton,* 410 U. S. 179 (1973), which invalidated as overly restrictive a Georgia statute in some respects broader than the Pennsylvania statute under consideration in this case. The Georgia statute had permitted abortion when, *inter alia,*

> "the fetus would very likely be born with a grave, permanent and irremediable mental or physical defect." 410 U. S. at 183.

The cases cited by Appellants at pages 34 to 36 of their Brief do not support the proposition for which they are cited. *Younger v. Harris,* 401 U. S. 37 (1971), (cited at page 34), concerned federal interference with a pending state criminal prosecution.

Lamm v. Volpe, 449 F. 2d 1202 (10th Cir. 1971), *cert. denied,* 405 U. S. 1075 (1972), (cited at page 36), involved federal supremacy. A federal statute required just compensation for the removal of outdoor advertising. The court rejected a state legislator's attempt to bring the removal within the police power, which would have obviated the need for compensation. The court held that the plaintiff lacked standing, and that the case was moot because the state had passed a just compensation statute.

Wyley v. Warden, 372 F. 2d 742 (4th Cir.), *cert. denied,* 389 U. S. 863 (1967), cited by Appellants at page

26. On remand in *Abele v. Markle, supra,* the three-judge district court reaffirmed its earlier decision that the abortion statute was unconstitutional.

34, is also inapplicable. That case involved a challenge to a state constitutional provision which had been repeatedly upheld by the state courts. Furthermore, the United States Supreme Court had had an opportunity to consider the provision, but had dismissed the appeal for want of a substantial federal question. In addition, the state Constitutional Convention Committee was considering its subcommittee's recommendation that the provision be deleted from the state constitution. Therefore, the court did not want to preempt the state's ongoing political processes.

No fundamental right was involved in the following cases cited by Appellants, so no compelling state interest was required to justify state intervention: *Munn v. Illinois,* 94 U. S. 113 (1876) (economic legislation);[27] *Hennington v. State of Georgia,* 163 U. S. 299 (1896),[28] (running freight trains on Sunday prohibited); *Staten Island Loaders v. Waterfront Commission,* 117 F. Supp. 308 (S. D. N. Y. 1953; 3-judge court), *aff'd.,* 347 U. S. 439 (1954) (public loaders barred from New York piers); *Lincoln Union v. Northwestern Company,* 335 U. S. 525 (1949)[29] (employment not affected by union membership or nonmembership); *Lawton v. Steele,* 152 U. S. 133 (1894) (preservation of fish); *Goldblatt v. Town of Hempstead,* 369 U. S. 590 (1962) (excavation for sand

27. In upholding a statute fixing maximum charges for the storage of grain in *Munn v. Illinois, supra,* the court noted that similar regulations had been in existence since the days of the Magna Charta. Abortion control statutes, on the other hand, are of relatively recent vintage. *Roe v. Wade,* 410 U. S. 113, 129 (1973).

28. This case was inadvertently cited in Appellants' Brief as *Harrington v. State of Georgia.*

29. This case was inadvertently cited in Appellants' Brief as *State v. Whitaker. Whitaker et al. v. North Carolina* was decided in conjunction with *Lincoln Union v. Northwestern Company, supra.*

and gravel); *Sweeney v. Murphy,* 39 App. Div. 2d 306, 334 N. Y. S. 2d 239 (1972) (property division fences); *Commonwealth v. Harmar Coal Company,* 452 Pa. 77, 306 A. 2d 308 (1973), *appeal dismissed,* 415 U. S. 903 (1974)[30] (water pollution).

Stricter scrutiny is required where a fundamental right is at stake. As Mr. Justice Goldberg stated in his concurring opinion in *Griswold v. Connecticut,* 381 U. S. 479, 496 (1965):

> "'While ". . . a . . . State may . . . serve as a laboratory; and try novel social and economic experiments," . . . I do not believe that this includes the power to experiment with the fundamental liberties of its citizens.'"

Section 5(a) impermissibly interferes with both the woman's right, in consultation with her physician, to terminate her pregnancy, and with the physician's exercise of professional judgment in determining whether a therapeutic abortion should be performed.[31] Accordingly, the provision is unconstitutional, and the decision of the three-judge court below should be affirmed.

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30. This case was erroneously cited in Appellants' Brief as *Commonwealth v. Harmon Coal Company.*

31. Although this section has assumed for the purpose of argument, that a fetus affected with a fatal genetic disease could be "viable", an alternative approach is possible. By describing viability in *Roe v. Wade, supra,* at 163, as the point at which the fetus "has the capability of *meaningful* life outside the mother's womb," (emphasis added), the Court arguably recognized that therapeutic abortions are permitted where the fetus is affected with a grave, permanent and fatal genetic defect. A child doomed to lose all function and become a vegetable by the age of three and to die by the age of seven or eight (50a) is hardly capable of "meaningful life." It is not, therefore, ever "viable" in the sense in which that term was used in *Roe v. Wade, supra.*

CONCLUSION.

For the reasons set forth above, we respectfully request Your Honorable Court to affirm the Judgment of the three-judge court below holding Section 5(a) of the Abortion Control Act unconstitutional and enjoining Appellants, their agents, employees, successors in interest, and all others acting in concert with them, from enforcing that section.[32]

Respectfully submitted,

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32. Appellants' request at page 43 of their Brief that Your Honorable Court delete the "or may be viable" language from section 5(a) improperly asks this Court to engage in judicial lawmaking.

It is the duty of the legislature to draft a statute which will withstand constitutional scrutiny. When the legislature has failed to do so, the provision must be stricken. This Court cannot rewrite the statute to save its constitutionality. *Yu Cong Eng v. Trinidad,* 271 U. S. 500 (1926). See also, *Blount v. Rizzi,* 400 U. S. 410, 419 (1971); *Dunne v. United States,* 138 F. 2d 137 (8th Cir.), *cert. denied,* 320 U. S. 790, *reh. denied,* 320 U. S. 814 (1943), *reh. denied,* 320 U. S. 815 (1944).

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare
of the Commonwealth of Pennsylvania
Et Al.

Appellants

vs.

JOHN FRANKLIN, M.D., Et Al.

Appellees

On Appeal From the United States District Court
For the Eastern District of Pennsylvania

AMICUS CURIAE BRIEF OF THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN AND MOTION FOR ORAL ARGUMENT BY AMICUS CURIAE

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In The
SUPREME COURT OF THE UNITED STATES
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MOTION FOR ORAL ARGUMENT BY AMICUS CURIAE

The Legal Defense Fund For Unborn Children is an organization whose purpose os to defend the constitutional rights of unborn children.

The interest of this amicus brief is to present to the Court a position that will not be presented by the parties. The amicus alleges that it can prove that Roe v Wade, 410 US 113(1973) is based on false evidence and millions of lives have been illegally exterminated. Of course, this requires the overruling of that case. If Roe v Wade were overruled, it would obviously be dispositive of this case.

Alan Ernest
Counsel for Amicus

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FRANK S. BEAL, Et al., Appellants

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JOHN FRANKLIN, M.D., Et al., Appellees

On Appeal from the United States District Court
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AMICUS CURIAE BRIEF ON BEHALF OF THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN IN SUPPORT OF THE APPELLANTS

The interest of the amicus is set out in the attached motion.

SUMMARY OF ARGUMENT

For the twelfth time, the Supreme Court is petitioned to overrule its abortion decision, Roe v. Wade, 410 US 113(1973), on the grounds that it is based on false evidence and millions of lives have been unconstitutionally exterminated. See THE CASE AGAINST THE SUPREME COURT, at 5-6, infra.

ARGUMENT

In 1975, the Supreme Court of West Germany held that the clause in the German Constitution, "Everybody has the right to life," also "includes unborn human beings," that "Abortion is an act of homicide," and the state had a "duty" under the Constitution "to protect unborn life." See translation in the 63 California Law Review at 1342, 1348-49. It is of paramount importance to examine how it is

possible for the high courts of two major nations, construing constitutional phrases that are in substance identical, to reach daimetrically opposing conclusions about the legality of millions of premeditated homicides. That examination, outlined in this brief, surely permits reasonable people to conclude beyond a reasonable doubt that the U.S. Supreme Court closed its eyes on the Constitution and condemned to death those victims whom the Constitution endeavours to preserve; and there appears to be no defense that will not amount to a claim that the Supreme Court is above the law,- as Hitler was to Germany, so the Supreme Court is to America.

The amicus's case was well presented in the ninth petition to overrule Roe v Wade(David Gaetano v Earl Silbert, United States Attorney for the District of Columbia, No. 77-1406, Cert. denied May 1, 1978):

"An EXHIBIT A established that Roe v Wade was based on false evidence by showing that(See EXHIBIT A, page 1, "Summary of Evidence"):

"1. even the Supreme Court admitted in Roe v Wade that if the unborn were a ' "person" within the language and meaning of the Fourteenth Amendment ' then the case for abortion on demand 'of course, collapses, for the fetus' right to life is then guaranteed specifically by the Amendment,' and

"2. the express, universal terms of the Fourteenth Amendment ('nor shall any State deprive <u>any person</u> of life . . . without due process of law') (emphasis added) on their face, protect the lives of the unborn, as everyone else, and

"3. the holdings of Chief Justice John Marshall (that can be traced through the Constitution, The Federalist Papers, and the Federal Convention of 1787) show that the Supreme Court has no lawful power to construe exceptions to express, universal terms (such as 'any person') unless the Court can

prove the exception to the express, universal terms beyond a reasonable doubt, and show that 'had this particular case been suggested' to the framers, the 'language would have been so varied, as to exclude it,' and

"4. the Supreme Court presented false evidence to support its conclusion in Roe v Wade that 'the word "person," as used in the Fourteenth Amendment, does not include the unborn' and but for the false evidence, there is not even a credible foundation, much less a compelling one, for denying the protection of the express, universal terms 'any person' to the lives of the unborn, and

"5. the truthful history corroborates that the express, universal terms 'any person' include the unborn, as they do all categories of persons, and more certainly than many groups. The Supreme Court included corporations and aliens as a 'person' within the language and meaning of the Fourteenth Amendment merely on the strength of the express, universal terms 'any person,' without any independent corroborating evidence whatsoever.(The unborn being the only persons ever excluded from the terms 'any person')

"In short, EXHIBIT A shows that the Supreme Court exactly violated the very letter of the Constitution, as well as its spirit, and condemned millions of victims to death whom the Constitution endeavours to preserve."

. . . .

"Roe v Wade asserts a second method . . . for the government to condemn persons to death:

"The First, set out in the Constitution, is by conviction by an impartial jury for violation of express laws enacted by the people and applicable to all in the state; with right to representation by counsel; with right to be acquitted unless found guilty beyond a reasonable doubt; with provision to stop execution if new evidence is discovered.

"The Second, set out in Roe v Wade, is for a Tribunal holding office for life(without assistance of counsel to defend the victims)to rule the victims out of the human race as inferiors, in violation of the very letter and spirit of the Constitution, falsifying evidence to make the homicides appear legal, and year after year to repeatedly deny applications showing the exterminations to be illegal.

. . . .

"(I)n 1975, the Supreme Court of Germany held that the clause in the German Constitution, "Everybody has the right to life," also "includes unborn human beings," that "Abortion is an act of homicide," and the state has a "duty" under the Constitution " to protect unborn life." See translation, 63 California Law Review at 1342, 1348-49. . . . (I)t is of paramount importance to examine how it is possible for the high courts of two major nations, construing constitutional phrases that are in substance identical, to reach diametrically opposing conclusions about the legality of millions of premeditated homicides. That examination, presented in EXHIBIT A, surely permits reasonable people to conclude beyond a reasonable doubt that the Supreme Court closed its eyes on the Constitution and condemned to death those victims whom the Constitution endeavours to preserve; and there appears to be no defense that will not amount to a claim that the Supreme Court is above the law,- as Hitler was to Germany, so the Court is to America.

"If it be true, as Chief Justice Marshall once held(see Marbury v Madison, 1 Cranch 137, 163, 176, 178) that "government of laws, and not of men," founded in a "written constitution" deriving its just power from the "supreme" "authority" of "the people" is "the greatest improvement on political institutions," then the overthrow of that government of laws by lawless federal judges may be the most heinous crime in the history of government.

. . . .

"APPENDIX

"THE CASE AGAINST THE SUPREME COURT

"The evidence appears to support the charge that some Justices of the U.S. Supreme Court have violated federal criminal statutes, such as:

"18 USC 242, Deprivation of rights under color of law,- It is a crime for government officials, acting under pretense of law, to willfully deprive persons of their rights secured by the U.S. Constitution. The documentation in EXHIBIT A, at the very least, permits reasonable people to conclude beyond a reasonable doubt that the unborn are persons whose lives are protected by the U.S. Constitution. The evidence that Justices specifically authorized killings throughout the United States, by a willfully false construction of the Constitution, would certainly permit a jury to conclude beyond a reasonable doubt that Justices, acting under pretense of law, had deprived millions of unborn persons of their right to life protected by the U.S. Constitution.

"22 D.C. Code 201, D.C. abortion statute,- The felony abortion statute only permits abortions in the District of Columbia to preserve the mother's life or health. The evidence that Justices specifically authorized non-therapeutic abortions in violation of the positive criminal statute, by a willfully false construction of the Constitution, would surely permit a jury to find beyond a reasonable doubt that Justices had aided and abetted those killings.

"22 D.C. Code 105 a, Conspiracy,- When Roe v Wade was decided, non-therapeutic abortions were illegal, not just in the District of Columbia, but generally throughout the United States. The evidence that Justices specifically authorized non-therapeutic abortions in violation of the States' positive criminal statutes, by a willfully false construction of the Constitution, would appear to permit a jury to find beyond a reasonable doubt that Justices conspired to effect those killings.

"18 USC 1503, Obstruction of justice,- It is a

crime to endeavor to obstruct or impede the due enforcement of the law of the land, even by conduct that is otherwise legal, if the motive is corrupt or dishonest. The evidence that the Supreme Court has been petitioned year after year to overrule Roe v Wade on the grounds that it is based on false evidence and millions of lives have been illegally exterminated, and year after year the Supreme Court summarily refused to even listen, would appear sufficient to permit a jury to conclude beyond a reasonable doubt that Justices had dishonestly endeavored to obstruct or impede the due enforcement of the law of the land.

"18 USC 1001, False statements,- The evidence that some Justices, within their official jurisdiction, made or adopted false statements in Roe v Wade, and repeated petitions indicated the false statements to be willful and knowing, might be sufficient to permit a jury to conclude beyond a reasonable doubt that some Justices had made false statements within 18 USC 1001.

"18 USC 371, Conspiracy,- It is not only a crime to conspire to commit any criminal offense, but also to conspire to defraud the United States by misrepresentation or the overreaching of those charged with the carrying out of the governmental intention. The evidence already mentioned would appear sufficient to permit a jury to find beyond a reasonable doubt that Justices had not only conspired to commit the above mentioned crimes, but also to defraud the United States.

"18 USC 1621, Perjury,- An oath of office to uphold the Constitution would probably not, under ordinary circumstances, support a charge of perjury. However, Chief Justice John Marshall held that for "judges" to "swear" to discharge their duties "agreeably to the constitution" and then "close their eyes on the constitution" and "condemn to death those victims whom the constitution endeavours to preserve" is worse than "solemn mockery," it is a "crime." Marbury v Madison, 1 Cranch at 179-180.

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1977

DAVID GAETANO and ALAN ERNEST, Next Friend of Unborn Child Roe and All Others Similarly Situated, PETITIONERS

vs.

EARL J. SILBERT, United States Attorney for the District of Columbia, RESPONDENT

No. 77-1406

WAIVER

The Government hereby waives its right to file a response to the petition in this case, unless requested to do so by the Court.

Wade H. McCree, JR.
Solicitor General

APRIL 6, 1978

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D.C. 20543

May 1, 1978

Alan Edward Ernest, Esq.
5713 Harwich Ct.
#232
Alexandria, VA 22311

RE: David Gaetano, et al.
v. Earl J. Silbert, etc.
No. 77-1406

Dear Sir:

The Court today denied the petition for a writ of certiorari in the above-entitled case.

Very truly yours,
MICHAEL RODAK, JR., Clerk
By
/s/ Edward Faircloth
Assistant Clerk

And silence, in the face of a charge, can be taken as an admission that the charge is true. See McCormick on Evidence 651-54(2d ed 1972).

CONCLUSION

For the twelfth time, the Supreme Court is petitioned to overrule its abortion decision, Roe v. Wade, 410 US 113(1973), on the grounds that it is based on false evidence and millions of lives have been unconstitutionally exterminated.

Can it be pretended that it is any longer the government of the United States,-any government of Constitution and laws,- wherein a Tribunal holding office for life and asserting to be the ultimate arbiter is charged year after year with millions of illegal homicides by false evidence, and year after year the Tribunal summarily refuses to even listen?

Alan Ernest
5713 Harwich Ct #232
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Counsel

No. 77-891

In the Supreme Court of the United States

OCTOBER TERM, 1977

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, **ROBERT P. KANE**, Attorney General of the Commonwealth of Pennsylvania, **THE COMMONWEALTH OF PENNSYLVANIA**, and **F. Emmett Fitzpatrick**,

Appellants,

vs.

JOHN FRANKLIN, M.D. and **OBSTETRICAL SOCIETY OF PHILADELPHIA**,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION AND BRIEF, AMICUS CURIAE OF AMERICANS UNITED FOR LIFE, INC. IN SUPPORT OF APPELLANTS BEAL, ET AL.

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INDEX

PAGE

Table of Citations i

Motion 1

Brief 3

Note 3

Argument 4

I. The Pennsylvania Statute Does Not Burden The Right To Terminate Pregnancy 4

II. The Pennsylvania Statute Rationally Relates To Valid State Interests By Protecting Viable Fetal Life From Medically Unnecessary Harm And The Physician From Prosecution 14

Conclusion 17

Appendix, The Pennsylvania Statute 18

TABLE OF CITATIONS

Cases

Carroll v. Skloff, 415 Pa. 47, 202 A.2d 9 (1964) 16

Chrisafogeoris v. Brandenberg, 55 Ill.2d 368, 304 N.E. 2d 88 (1973) 16

Clarke v. State, 117 Ala. 1, 23 So. 671 (1898) 15

Eich v. Town of Gulf Shores, 293 Ala. 95, 300 So.2d 354 (1974) 16

Eisenstadt v. Baird, 405 U.S. 438 (1972) 11

Griswold v. Connecticut, 381 U.S. 479 (1965) 11

PAGE

Hodgson v. Anderson, 378 F. Supp. 1008, 1016 (D. Minn. 1974), appeal dismissed sub. nom. Spannas v. Hodgson, 420 U.S. 903 (1975) 6

Leigh v. Olson, 385 F.Supp. 255 (D. N.D. 1974) 6

Libbee v. Permanente Clinic, 268 Ore. 258, 518 P.2d 636 (1974) 16

Lindsey v. Normet, 405 U.S. 56, 74 (1972) 17

Maher v. Roe, 432 U.S. 464, 474, 476, 478 (1977) 6, 11, 13, 14, 17

Massachusetts Bd. Retirement v. Murgia, 427 U.S. 307, 314 (1976) 17

Meyer v. Nebraska, 262 U.S. 390 (1923) 11, 13

Mone v. Greyhound Lines Inc., 331 N.E.2d 916 (Mass. 1975) 16

Moore v. City of East Cleveland, 431 U.S. 494 (1977) 12

Morgan v. State, 148 Tenn. 417, 256 S.W. 433 (1923) 15

Paris Adult Theater v. Slaton, 413 U.S. 49 (1973) 12

Pennsylvania v. McKee, 1 Add. 1 (Pa. 1797) 15

Pierce v. Society of Sisters, 268 U.S. 510 (1925) 11, 13

Planned Parenthood v. Danforth, 428 U.S. 52, 64-65, 81-83 (1976) 6, 7

Planned Parenthood Assoc. v. Fitzpatrick, 401 F. Supp. 554, 572 (E.D. Pa. 1975) 6

Queen v. West, 2 Carrington and Kirwan 784 (Nisi Prius 1848) 15

Rex v. Senior, 1 Moody's Crown Cases Reserved 346, 168 English Reports 1298 (1832) 15

Roe v. Wade, 410 U.S. 113, 152-153, 154, 160, 160 n. 59, 163, 164 (1973) 4, 6, 7, 8, 9, 10, 11, 13, 14

PAGE

Stanley v. Georgia, 394 U.S. 557 (1969) 12

State v. Cooper, 22 N.J.L. 52 (1849) 15

U.S. v. Orito, 413 U.S. 139 (1973) 13

U.S. v. Reidel, 402 U.S. 351 (1971) 12

U.S. v. 12 200-ft. Reels, 413 U.S. 123 (1973) 13

Wynn v. Scott, No. 75 C 3975 (N.D. Ill., filed April 12, 1978) (Circuit Judge Tone and District Judges Marshall and Kirkland) 5

Young v. American Mini Theatres, 427 U.S. 50 (1976) .. 12

Statutes

Abortion Control Act, Act No. 209 of 1974, 35 P.S. Section 6601 et. seq. 4 Pa. Leg. Serv. 74, 625 18

Ill. Rev. Stat. chap. 38, sec. 81-26(1), (2) (1976) 5, 8

Mass. Gen. Laws Ann. ch. 112, sec. 12J (West) (Supp. 1976-77) (amended) 8

Articles and Books

4 W. Blackstone, Commentaries * 198 (1769) 15

Bracton, The Laws and Customs of England, III, ii, 4 quoted and translated in Means "The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality," 14 N.Y.L.F. 411, 419 (1968) 15

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Capron, The Law Relating to Experimentation with the Fetus, In National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Appendix to Report and Recommendations: Research on the Fetus (DHEW Pub. No. (OS) 76-128, 1975) 13-21 .....8, 15, 16

	PAGE
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NOTE, Fetal Experimentation: Moral, Legal and Medical Implications, 26 Stan. L. Rev. 1191 (1974)	8
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Means, "The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968; A Case of Cessation of Constitutionality," 14 N.Y.L.F. 411, 419 (1968)	15
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W. Prosser, Law of Torts, sec. 55, 335, 338, 338 n. 7 (4th ed. 1971)	16
Stedman's Medical Dictionary 1551 (23d ed. 1976)	10
Symposium On the Report and Recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Research on the Fetus, 22 Vill. L. Rev. 2, 297-417 (1976-77)	8

In the Supreme Court of the United States

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FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. Emmett Fitzpatrick,
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Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

PURPOSE OF THIS MOTION

J. Jerome Mansmann, Special Assistant Attorney General of Pennsylvania, representing appellants, has given consent for the filing of this amicus brief. Roland Morris, attorney for the appellees, has indicated that he will interpose no objection to the filing of this brief and that he understands this will be treated as the consent of the appellees under Rule 42(2) of the Supreme Court. Letters from each attorney stating the above have been filed with the Clerk of this Court.

INTEREST OF THE AMICUS

Americans United for Life (AUL) is a national educational foundation organized to educate and promote better understanding of the humanity of the unborn and the value of human life. Its national office is located in Chicago, Illinois, and its membership includes approximately 20,000 persons located in every state of the union.

The Board of Directors and Officers of Americans United for Life include the following:

This brief Amicus Curiae is filed in support of the Appellants, Beal et al., and also to present the arguments to this Court that the Pennsylvania statute challenged herein does not burden or impede the woman's right to privacy.

Respectfully submitted,

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June 6, 1978

In the Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. Emmett Fitzpatrick,
Appellants,

vs.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,
Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF AMICUS CURIAE

NOTE

The Questions Presented and The Statement of the Case are omitted from this Amicus Curiae Brief since they are amply stated in the Brief of Appellants Beal, et al.

ARGUMENT

I.

THE PENNSYLVANIA STATUTE DOES NOT IMPEDE OR BURDEN THE RIGHT TO TERMINATE PREGNANCY

The Pennsylvania statute attempts to penalize adverse treatment of the viable fetus during the course of pregnancy termination when such adverse treatment is unnecessary to the protection of maternal health or the effectuation of the woman's right of privacy.

In their Motion to Dismiss or Affirm at 3, appellees argue that "the purpose of an abortion is *invariably* to obviate rather than facilitate a live birth." (Emphasis added.) Appellees thus assert that a woman's constitutional right to abortion "invariably" includes a right to produce a dead fetus. They argue so without reference to the age or development of the fetus. This is the issue which this Court presently confronts.

In order for this Court to find that the Pennsylvania statute burdens abortional privacy, it logically must first find that the woman's abortional freedom permits her actively to seek the death of her fetus even though there is a possibility that the fetus might otherwise survive. Nowhere has this Court held that the right secured in *Roe* v. *Wade,* 410 U.S. 113 (1973), is so expansive as appellees suggest. Fetal death might be the inevitable result of early abortion, but this Court has never held that the right of privacy is to be equated invariably with a "right" to directly seek fetal injury or death as appellees assert in their Motion to Dismiss or Affirm. That right of privacy does not include the right to a dead fetus.

As a Three Judge Federal Court has recently unanimously stated, upholding an Illinois statute[1] with an effect similar to that now before this Court:

> [The statute] does not require that the physician increase the risk to the woman in order to save the fetus. If, however, there are instances where a physician has a choice of procedures, both of equal risk to the woman, the physician must choose the procedure which is least likely to kill the fetus. This choice would not interfere with the woman's right to terminate her pregnancy. It never could be argued that she has a constitutionally protected right to kill the fetus. She does not.

Wynn v. *Scott,* No. 75 C 3975 (N.D. Ill., filed April 12, 1978) (Circuit Judge Tone and District Judges Marshall and Kirkland).

Applying this reasoning to the Pennsylvania statute we see that the Pennsylvania statute does not regulate "abortion" at all in the sense that it would burden or impair the woman's right to end pregnancy safely. It penalizes hostile activity directed toward the fetus unrelated to the exercise of the woman's privacy interest. The Pennsylvania law may be conceived to burden the right recognized in *Roe* only if that right is understood to be indistinguishable from license to commit feticide. This Court has held that the state maintains an interest in the fetus throughout

---

[1] ILL. REV. STAT. chap. 38, sec. 81-26(1) (1976): "No person who performs or induces an abortion after the fetus is viable shall fail to exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted. Any physician or person assisting in the abortion who shall intentionally fail to take such measures to encourage or to sustain the life of viable fetus or child, and the death of the viable fetus or the child results, shall be deemed guilty of a Class 2 felony."

pregnancy, *Maher* v. *Roe*, 432 U.S. 464, 478 (1977), and a compelling interest upon the onset of viability, *Roe*, 410 U.S. at 163.

The District Court misread these holdings to mean that any regulation on behalf of the fetus prior to the time the fetus "is viable" violates the Constitution.[2] But such an

[2] The District Court's conclusion rested upon the assumption that this Court found that viability could not exist prior to the 24th week of gestation as a matter of law. *Planned Parenthood Assoc.* v. *Fitzpatrick*, 401 F.Supp. 554, 572 (E.D. Pa. 1975). In fact, this Court has strongly emphasized that "viability" is a flexible concept which must be applied on a case by case basis in accord with developing medical technology, and has specifically rejected any inference that a specific time in gestation must be established to mark the onset of viability *Roe*, 410 U.S. at 164; *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 64-65 (1976). That the Pennsylvania statute may regulate abortion upon behalf of the fetus prior to 24 weeks gestation by no means causes it to become automatically unconstitutional.

The District Court relied upon *Hodgson* v. *Anderson*, 378 F.Supp. 1008 (D. Minn. 1974), *appeal dismissed sub nom. Spannas* v. *Hodgson*, 420 U.S. 903 (1975) and *Leigh* v. *Olson*, 385 F.Supp. 255 (D. N.D. 1974). *See Planned Parenthood* v. *Fitzpatrick*, 401 F.Supp at 572. *Leigh* concerned possible saving construction of a North Dakota abortion statute in the wake of *Roe*, not with the standard of care of the physician where the fetus is or may be viable. *Leigh*, 385 F.Supp. at 259-261. *Hodgson* concerned a statute which fixed the time of viability and "potential viability" at a definite point. *Hodgson* v. *Anderson*, 401 F.Supp. at 1016.

It is difficult to see in what manner *Leigh* is applicable in the present context. But the District Court in the instant case apparently derived its position that any regulation on behalf of the fetus prior to the 24th week of pregnancy is unconstitutional from *Hodgson*. *Id.* Under *Danforth*, 428 U.S. at 64-65, however, the Minnesota statute is unconstitutional not because it purports to regulate prior to the 24th week of pregnancy, but because it interferes with the physician's discretion. It is to be noted that the Pennsylvania statute leaves the determination whether the fetus is or may be viable to the physician.

analysis of the decision in *Roe* perverts its underlying rationale. State regulation of abortion is not forbidden by the Constitution as a matter of absolute, abstract principle but only to the extent that such regulation burdens or obstructs the exercise of the woman's abortional freedom without compelling purpose. "Regulation" of abortion on behalf of maternal health in the first trimester would not be forbidden if it did not in fact burden or infringe upon abortional privacy. Similarly, regulation on behalf of the fetus, whether or not such regulation is conceived to impact upon the second trimester, requires no compelling state purpose if it does not obstruct exercise of the right secured in *Roe*.

Obviously, in the earlier stages of pregnancy, abortion inevitably causes fetal death under present medical technology since, regardless of the method employed, the fetus will not survive—is not "viable." Hence the state interest in fetal life in earlier pregnancy might only be secured by proscribing altogether the abortion procedure, which it may not do without compelling interest at stake.[3]

[3] *Danforth*, 428 U.S. at 81-83. The District Court finds no support for its position in *Danforth*, where this Court held unconstitutional a portion of a Missouri statute which required the physician to employ the same standard of care toward a fetus during the course of abortion that he would should it be intended that the fetus be born alive. *Id.* A literal reading of the Missouri statute would obviously have precluded all abortion since under this standard, no abortion whatever might be performed. But the Pennsylvania law presently before this Court clearly contemplates that abortion shall be performed. Otherwise, it would not provide that abortion should be performed in a manner to maximize opportunity for fetal survival. Further, the Pennsylvania statute applies at a time in pregnancy when it is possible that the life of the fetus might be preserved in some manner other than through merely continuing pregnancy. Finally, the restrictions upon physician technique do not apply to the extent that some increased risk to the mother might arise and, hence, do not interfere with any attempt to maximize maternal health through abortion.

Moreover, state regulation during the course of abortion on behalf of fetal life prior to viability would serve no rational purpose since the fetus must inevitably die as result of any abortion performed.[4] But it does not follow,

[4] The state, however, is not wholly disinterested in the manner abortion is performed even prior to the time that the fetus is or may be viable. Thus, numerous statutes and regulations have been adopted to control fetal experimentation conducted during the course of or as an incident to abortion. Such regulation is justified upon the same grounds as the Pennsylvania statute: neither fetal experimentation nor any other adverse treatment unnecessary to fetal expulsion falls within the protected zone of privacy recognized in *Roe*. *See, e.g.* ILL. REV. STAT. ch. 38, sec. 81-26(2) (1976); MASS. GEN. LAWS ANN. ch. 112, sec. 12J (West) (Supp. 1976-77) (amended); NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, REPORT AND RECOMMENDATIONS: RESEARCH ON THE FETUS, [DHEW Publication No. (OS) 76-127, 1975], *also printed in* 40 Fed. Reg. 33,530 (1975) (partially codified in 45 C.F.R. sections 46.101-.301 (1976)), hereinafter COMMISSION REPORT. For survey of state and common law relating to fetal research, see Capron, *The Law Relating to Experimentation with the Fetus*, In NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *Appendix* to REPORT AND RECOMMENDATIONS: RESEARCH ON THE FETUS (DHEW Pub. No. (OS) 76-128, 1975). Note that the Commission defined "fetus" as a human being from the time of implantation until a determination is made that the fetus is viable or possibly viable. COMMISSION REPORT, *supra*, at 40 Fed. Reg. 33,531 (1975). The Commission then stated: "If it is viable or *possibly viable*, it is thereupon designated an infant." *Id.* (Emphasis added). *Cf. Symposium On the Report and Recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Research on the Fetus*, 22 VILL. L. REV. 2, 297-417 (1976-77); Note *Fetal Experimentation: Moral, Legal and Medical Implications*, 26 STAN. L. REV. 1191 (1974); Burger, *Reflections of Law and Experimental Medicine*, 15 U.C.L.A. L. REV. 436 (1968).

even in earlier pregnancy, that the woman's privacy interest in pregnancy termination is identical to any presumed "unlimited right to do with the fetal body what one wishes" even to the extent of medically unnecessary killing. Abortional privacy does not rest upon such a principle even in relation to the woman. *Roe*, 410 U.S. at 154.

Roe held that at that point where, under contemporaneous medical technology, an exercise of abortional freedom might be separated from fetal death—at viability—the state's interest in abortion becomes "compelling" and warrants direct interference with pregnancy termination. *Roe*, 410 U.S. at 163. But selection of viability as the critical point when the state might directly interfere with abortion on behalf of the fetus can only be justified in relation to a concept of the privacy right at stake in abortion based upon an inherent distinction between pregnancy termination and feticide. If an essential element of the right recognized in *Roe* is the "right" to prevent production of a living infant, then it is absurd to allow that the state may proscribe an exercise of the "right" to prevent production of a living infant at viability, which is precisely the time when a living infant may in fact be produced.[5]

[5] The District Court wholly failed to account for this Court's definition of viability in *Roe* as *"potentially* able to live outside the mother's womb, albeit with artificial aid," *Roe*, 410 U.S. at 160 (emphasis added), when it reached the conclusion that viability may not be conceived to occur before 24 weeks gestation and that "may be viable" carves out time in pregnancy inconsistent with *Roe*. "Viability" is not a fact which can be established with certainty until an infant actually survives upon birth. While a child is *in utero* and is "potential" the physician can do little more than weigh probability that a child with a given birth weight would survive at birth. Birth weight itself is unknown *in utero* and must be hypothesized based upon duration of pregnancy. Finally, the duration

(footnote continued)

In the context of *Roe*, it is far more rational to assert, as does your amicus, that the right to terminate pregnancy is no more or less than the right to expel the fetus from the womb and does *not* include a "right" to production of a dead fetus. Perceived in this manner, the state maintains an interest on behalf of fetal life (and in the manner in which the abortion procedure is performed) to the extent that an exercise of this right would not inevitably result in fetal death. To the extent that the woman's fundamental privacy interest and the state's interest in fetal protection might both be realized there is no logical or constitutionally cognizable reason why the state might not act to protect its interest while fully permitting the woman to exercise her right to termi-

(footnote continued)
of pregnancy is itself not always certain. "Potentially" able to live outside the womb thus is not the same as "certainly" able to live outside the womb either in logic or medical practice. The concept of potentiality itself carries with it the very aspect of contingency and uncertainty expressed where the Pennsylvania statute regulates abortion according to the physician's judgment that the fetus "may be" viable. This is apparently the view of the authorities which this Court cited in support of its definition of viability, *Roe*, 410 U.S. at 160 n. 59: the fetus is to be considered "potentially" able to survive when he *might* survive upon birth.

DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 1713-14 (25th ed. 1974) does not refer to an age criterion as an indication of viability. But. L. HELLMAN & J. PRITCHARD, WILLIAMS OBSTETRICS (14th ed. 1971) allows that "viability" has been interpreted to exist between 400 grams fetal weight or 20 weeks of gestation and 1000 grams or 28 weeks, *id.* at 493, and takes the position that 20 weeks or 400 grams is the point at which viability might "logically be set" in view of fetal survival at that age. *Id.* at 1027. STEDMAN'S MEDICAL DICTIONARY 1551 (23rd ed. 1976) likewise refers to viability as usually connoting "a fetus that has reached 500 grams in weight and 20 gestational weeks." It is thus not at all certain, as the District Court seemed to assume, that the Pennsylvania statute even purports to regulate on behalf of the fetal life prior to the time this Court has determined is the threshold of the compelling state interest in the fetus.

nate pregnancy. This conclusion is fully consistent with analogies drawn from other areas of law where privacy interests of a fundamental character have found recognition under the Constitution.

The Pennsylvania statute cannot easily be conceived to justify governmental interference in an area of traditional "intimacy" or privacy as in *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). A decision to cause fetal harm bears no necessary relationship to the decision of an individual whether or not to "beget or bear" a child protected in *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972).

The parent maintains a fundamental private right to control the education and development of children—a right conceived by this Court to be "closely analogous" to that of *Roe*. *Maher*, 432 U.S. at 476. Indeed, this Court has identified *Meyer* v. *Nebraska*, 262 U.S. 390 (1923) and *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) as direct precedents under the Fourteenth Amendment to recognition of abortional freedom. *Roe*, 410 U.S. at 152-153. Though the parent maintains a fundamental privacy interest in relation to the child, it does not follow that every state action which purports to regulate the manner in which the education or development of the child is pursued must rest upon a "compelling" interest.' The zone of parental privacy has never been held to encompass such a broad area. The state would be hard put to show that each and every of its myriad statutes and administrative regulations which control the education of children are grounded in a compelling purpose. A substantial portion of governmental control of the child's educational development bears little, if any, relation to manifestation of the parents' fundamental privacy interest—indeed, most such governmental regulations create no obstacles to parental control, but merely designate the context in which control

shall be exercised. Similarly, the Pennsylvania statute before this Court creates no obstacle to abortion but is fashioned to protect the state's interest in the fetus to the extent that that interest may be protected without obstructing the woman's right to terminate her pregnant condition.

Because the Pennsylvania statute controls only the manner or context in which abortion is performed on behalf of valid interests it does not block effectuation of any privacy interest as does, for example, a zoning ordinance which penalizes any exercise of familial cohabitation beyond the nuclear family. *Moore* v. *City of East Cleveland,* 431 U.S. 494 (1977). The Pennsylvania statute does no more than control the manner of distribution of the service sought and offered without effectively proscribing it. From this perspective, it is certainly no more a burden upon abortional liberty to require that abortion be effectuated without unnecessary harm to the fetus than it is a burden upon First Amendment freedom to require that purveyors of certain printed materials be located in a specified manner when it is demonstrated that harm to valid governmental interests might otherwise result. *Young* v. *American Mini Theatres,* 427 U.S. 50 (1976).

Indeed, any asserted right to inflict unnecessary harm upon the fetus during the course of abortion is not a "right" at all since it falls outside the zone of privacy wherein the woman may effectively cause fetal expulsion. By analogy, though the right of privacy protects the individual from state prosecution where possession of offensive materials is within the privacy of the home, *Stanley* v. *Georgia,* 394 U.S. 557 (1969), possession of the same materials outside the boundaries of the protected zone of the home is not so protected. *U.S.* v. *Reidel,* 402 U.S. 351 (1971); *Paris Adult Theater* v. *Slaton,* 413 U.S. 49 (1973); *U.S.* v. *Orito,* 413 U.S. 139 (1973); *U.S.* v. *12 200-ft. Reels,* 413 U.S. 123 (1973).

Thus the Pennsylvania regulation before this Court is different in kind from the laws invalidated in previous abortion decisions. Just as the Connecticut regulation of state funds challenged in *Maher,* the Pennsylvania regulation places no obstacles—absolute or otherwise—in the pregnant woman's path to abortion. The aborting woman suffers no disadvantage as a consequence of Pennsylvania's attempt to allow the child to live if that is possible. The woman's or doctor's desire to kill the fetus in addition to terminating the pregnancy must not override the state's interest in the child.

The fact that the aborting woman may not be assured that the fetus will be aborted dead or the inability of the woman to practice a prenatal policy of eugenic death selection based upon supposed physical defects is constitutionally irrelevant. If the state wishes to encourage all viable children to live regardless of physical condition, circumstances of birth or "wantedness" by the parents, this is a matter appropriately for the state so long as the limited right of the woman recognized in *Roe* may be exercised.[6]

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[6] Although appellees suggest that the "purpose" of abortion is "invariably to obviate live birth," the Constitution does not guarantee any particular purpose must be accomplished through an exercise of any privacy interest. Thus, parents who seek foreign language instruction of religious education for their child—right protected by *Meyer* and *Pierce*—no doubt desire that the child will become linguistically competent or religiously orthodox just as the woman who procures abortion may prefer the fetus will not survive the procedure. But the Constitution is not violated because the woman's expectation of a dead fetus remains unfulfilled, any more than it is violated should the child sent to parochial school become heterodex.

The Pennsylvania statute before this Honorable Court in no way denies or infringes upon the recognized right of the woman to terminate pregnancy safely. It is solely directed toward protection of the fetus from unnecessary harm caused during the course of abortion and cannot be conceived to infringe upon the woman's right to end her pregnant condition. With regard to the right recognized in *Roe*, the woman is in the same position she was prior to enactment of the statute. *Maher*, 432 U.S. at 474. Since the Pennsylvania statute infringes upon no fundamental right, it is valid if rationally related to valid state interests.

II.

THE PENNSYLVANIA STATUTE RATIONALLY RELATES TO VALID STATE INTERESTS BY PROTECTING VIABLE FETAL LIFE FROM MEDICALLY UNNECESSARY HARM AND THE PHYSICIAN FROM PROSECUTION.

The court below misconstrued the Pennsylvania standard "may be viable" as shortening the period of viability to something less than 24 to 28 weeks. This is not so. The standard "may be viable" does not refer to a shortened fetal gestational period but rather to the subjective medical judgment of the attending physician. The determination of viability is a subjective medical judgment to be made by the attending physician in each case based upon the relevant data and in the exercise of a reasonable degree of medical certainty. Where a physician in the exercise of that subjective judgment cannot say with certainty that a fetus "is viable" yet performs a late abortion without regard to the reasonable possibility that the fetus is viable

he certainly assumes a known risk for whatever consequences to a live born infant may result.[7]

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[7] Those consequences are the consequences which flow from the killing of a human being. 4 W. BLACKSTONE, COMMENTARIES * 198 (1769); 3 COKE, INSTITUTES * 58 (1648); BRACTON, THE LAWS AND CUSTOMS OF ENGLAND, III, ii, 4, quoted and translated in Means, *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411, 419 (1968); *Rex* v. *Senior*, 1 *Moody's Crown Cases Reserved* 346, 168 *English Reports* 1298 (1832); *Queen* v. *West*, 2 *Carrington and Kirwan* 784 (Nisi Prius 1848).

American authorities are in accord. A commission on Massachusetts law headed by Joseph Story reported in 1844: "If a child be born alive and then die, in direct consequence of potions administered, or violence done before its birth, or during its birth, it is the killing of a human being." Phillips and Walcott, *Report of the Criminal Law Commissioners on the Penal Code of Massachusetts* ch. 7, sec. 33 (1844). *Cf. Pennsylvania* v. *McKee*, 1 Add. 1 (Pa. 1797); *Clarke* v. *State*, 117 Ala. 1, 23 So. 671 (1898); *Morgan* v. *State*, 148 Tenn. 417, 256 S.W. 433 (1923); *State* v. *Cooper*, 22 N.J.L. 52 (1849). The National Commission for the Protection of Human Subjects advised the Commission in 1975 that if parents consented to, or a physician inflicted, injuries on the unborn child during an abortion and the child was born and died of the injuries, "the most dire consequences for the parents or physician would come under the criminal law, which regards it as murder or manslaughter if prenatal injuries bring about postnatal death." Alexander M. Capron, *The Law Relating to Experimentation with the Fetus*, COMMISSION REPORT, supra at n. 2, *Appendix to Research on the Fetus*, pp. 13-21. *Cf.* R. PERKINS, CRIMINAL LAW, *at* 30 (2nd ed., 1969): If a pregnant woman is injured by some act of another person and a child is born alive who dies of the injury inflicted before birth, or who dies because the injury caused it to be born too soon, this is homicide."

Once an infant is born alive it is irrelevant whether it is to be considered "viable" or not: "As we have seen, nonviable fetuses

(footnote continued)

The Pennsylvania statute frees the physician to perform late abortion where it is uncertain whether the fetus is viable, so long as abortion is performed in accord with the statutory standard of care. As such, the statute protects the physician from prosecution or civil suit[8] which may arise out of the contingent nature and result of late abortion performed in such circumstances.

Further, it might never be possible to protect the compelling interest of the state in the viable fetus unless the

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(footnote continued)

ex utero have been regarded as persons under the common law of crimes, protected against murder and assault; under statutory law a still greater burden of care (than might be warranted by its "nonviability") may be imposed as in some abortion laws, and restrictions may be placed on what can be done with it, as in the statutes governing what Louisiana vividly denominates "the crime of human experimentation." The common law of torts and property, and the rules of equity, also regard the nonviable fetus *ex utero* as a "person" to be accorded the full protection of the law. Although its small size and weight and general lack of development preclude such a fetus from having any true independent existence, the fact of its physical separation from its mother is sufficient to confer upon it the presumption of such independence." Capron, *supra*, 13-25 (footnotes omitted).

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[8] *Carroll* v. *Skloff*, 415 Pa. 47, 202 A. 2d 9 (1964). *Cf.* W. PROSSER, LAW OF TORTS, sec. 55, at 335 (4th ed. 1971). The majority of courts have held that the viable fetus *in utero* is a "person" for purpose of wrongful death statutes. *Id.* at 338, 338 n. 7. *See also Chrisafogeoris* v. *Brandenberg*, 55 Ill.2d 368, 304 N.E. 2d 88 (1973); *Libbee* v. *Permanente Clinic*, 268 Ore. 258, 518 P.2d 636 (1974); *Eich* v. *Town of Gulf Shores*, 293 Ala. 95, 300 So.2d 354 (1974); *Mone* v. *Greyhound Lines Inc.*, 331 N.E. 2d 916 (Mass 1975).

state is empowered to control the manner of abortion where the fetus may be viable. This is so because the physician—in order to avoid prosecution for performance of abortion where it develops that the fetus is in fact viable—would be strongly motivated to perform "abortion" to assure that the fetus will not survive upon birth, thus tending to prove the fetus was not viable in the first place.

Consequently, the standard created by the Pennsylvania statute protects both physician and the viable fetus without in any way interfering with the woman's right to abort. As such, the Pennsylvania statute rationally relates to valid state interests and is clearly constitutional. *Maher*, 432 U.S. at 478; *Lindsey* v. *Normet*, 405 U.S. 56, 74 (1972); *Massachusetts Bd. Retirement* v. *Murgia*, 427 U.S. 307, 314 (1976).

CONCLUSION

The Pennsylvania statute does not burden or impede the right to privacy and is rationally related to valid state interests.

Respectfully submitted,

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APPENDIX

The Pennsylvania Abortion Control Act, P.L. 209 of 1974

Section 5. Protection of Life of Fetus.

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

STATE OF ILLINOIS)
) ss.
CITY OF CHICAGO)

CERTIFICATE OF SERVICE

I, Dennis J. Horan, one of the attorneys for Amicus Curiae, being a member of the Bar of the Supreme Court of the United States, do hereby certify I have caused a true and correct copy of the foregoing motion, to be served upon Appellants and Appellees they being all the parties of record by depositing such motion in a United States Post Office mailbox, with first-class postage prepaid addressed to J. Jerome Mansmann, at his office of record, Sixth Floor-Porter Building, 601 Grant Street, Pittsburgh, Pennsylvania 15219, attorney for Appellants; and Roland Morris, 16th Floor, 100 South Broad Street, Philadelphia, Pennsylvania 19110, attorney for Appellees, this 6th day of June, 1978.

.....
Dennis J. Horan

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. Emmett Fitzpatrick,

Appellants,

v.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees.

BRIEF OF AMICUS CURIAE FOR UNITED STATES CATHOLIC CONFERENCE

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TABLE OF CONTENTS

Page

CONSENT OF THE PARTIES 1

IDENTIFICATION AND INTEREST OF THE AMICUS 2

SUMMARY OF THE ARGUMENT 3

ARGUMENT

I. BIOLOGICAL DATA RATHER THAN A SOCIETAL CONSENSUS MUST BE THE CRITERIA USED TO ACHIEVE AN ADEQUATE AND JUST DEFINITION OF "HUMAN LIFE." 4

II. THE PENUMBRA OF PROTECTIONS AFFORDED BY THE BILL OF RIGHTS GUARANTEES A FULL "PERSON-HOOD" RIGHT TO THE UNBORN 7

III. PRECIOUS CONSTITUTIONAL RIGHTS, PARTICULARLY THOSE WHICH PROTECT AND DIGNIFY HUMAN LIFE, ARE REMOVED FROM THE POLITICAL ARENA AND EXIST INDEPENDENT OF THE WORKINGS OF POPULAR OPINION 10

IV. TWENTIETH CENTURY SCIENTIFIC DATA BELIES ANTIQUATED NOTIONS OF "QUICKENING" AND MUST SERVE AS THE STANDARD TO DETERMINE THE NATURE OF HUMAN LIFE 13

V. CONCLUSION 17

TABLE OF AUTHORITIES

Cases:

Baird v. Bellotti, 428 U.S. 132, 96 S. Ct. 2857 (1976).....17

Byrn v. New York City Hospital, 42 N.Y. 2d, 194-199 4

Doe v. Bolton, 410 U.S. 172 (1973).....4

Griswold v. Connecticut, 381 U.S. 479 (1965).....8,9

Loving v. Virginia, 388 U.S. 1 (1967).....9

Maynard v. Hill, 125 U.S. 190 (1877).....9

Meyer v. Nebraska, 262 U.S. 390 (1923) 9

Pierce v. Society of Sisters, 268 U.S. 510 (1925) 9

Planned Parenthood v. Danforth, 428 U.S. 52, 96 S. Ct. 2831 17

Roe v. Wade, 410 U.S. 113 (1973).....4,5,6,7,8,9,12,17

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Appellants,

v.

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees.

BRIEF OF AMICUS CURIAE FOR UNITED STATES CATHOLIC CONFERENCE

CONSENT OF THE PARTIES

Both the appellants and the appellees have consented in writing to the filing of this brief amicus curiae by the United States Catholic Conference.

INTEREST OF THE AMICUS CURIAE

I.

Identification of the Amicus

The United States Catholic Conference is a nonprofit corporation and an agency through which the Catholic Bishops of the United States collaborate with other members of the Church—priests, religious and laity—in areas where voluntary collective action on an interdiocesan and national basis can benefit the Church and Society.

USCC is an agency of the Catholic Bishops of the United States. Its predecessor, established in 1919, was known as the National Catholic Welfare Conference. The prime purpose of USCC is to unify and coordinate activities of the Catholic people of the United States in programs and works of education, social welfare, health and hospitals, family life, immigrant aid, poverty assistance, civic education, youth activities, communications and public affairs, with emphasis on the preservation of religious liberty in America.

II.

Interest of the Amicus in This Case

The issue presented in this case is profound and directly affects over a million unborn each year. It is the conviction of this amicus that matters of such fundamental import require consideration from all quarters. A spirit of service to the Court prompts this amicus to submit the arguments contained herein for the Court's consideration.

SUMMARY OF THE ARGUMENT

I.

Biological data rather than a societal consensus must be the criteria used to achieve an adequate and just definition of "human life."

II.

The penumbra of protections afforded by the Bill of Rights guarantees a full "personhood" right to the unborn.

III.

Precious constitutional rights, particularly those which protect and dignify human life, are removed from the political arena and exist independent of the workings of popular opinion.

IV.

Twentieth century scientific data belies antiquated notions of "quickening" and must serve as the standard to determine the nature of human life.

ARGUMENT

I.

BIOLOGICAL DATA RATHER THAN A SOCIETAL CONSENSUS MUST BE THE CRITERIA USED TO ACHIEVE AN ADEQUATE AND JUST DEFINITION OF "HUMAN LIFE"

It is generally true that fetal life is viable if it is left alone. Thus, the issue of viability presented in the instant case is a product of the Abortion Cases and can only be understood as such.[1] These decisions are marked by many inner tensions and inconsistencies, but nowhere are such tension and inconsistency greater or more significant than in the Court's view of unborn life. The dynamism which shapes the present controversy flows directly from the Court's treatment of prenatal life in *Roe v. Wade.*

The principal source of difficulty is that the Court in *Roe v. Wade* created the category of "potential life." Biology recognizes no such category. The human fetus is, in the view of life science, a human life from the onset of conception. It is unquestionably alive; it cannot be characterized as anything less than human. *Byrn v. New York City Hospital,* 42 N.Y. 2d 194-199 91972). Biologically, it is not "potential" human life; it is actual human life in its early stages of growth. It is human life with potential for further development.

The Court's use of the expression "potential human life" manifests a rejection of biological criteria. This is accompanied by the substitution of what might be termed a sociological or normative definition of "human"—a substitution which is crucial, as it provides the rationale of the entire holding. Fetal life can only be "potential" human life if

[1]Roe v. Wade, 410 U.S. 113 (1973). Doe v. Bolton, 410 U.S. 172 (1973).

one is prepared to accept the view that the possession of biologically human life is insufficient to render the possessor "human." Thus, the decision in *Roe v. Wade* is saved from irrationality only by its acceptance of a definition of human life for constitutional purposes that rejects life science and extends recognition as life only to that which societal consensus can agree is human.

It does not follow from the Court's reference to the uncertainty of various segments of our society as to when human life begins that there is any confusion on this point in the life science community. Quite the contrary. There, a uniform consensus exists that the fetus is a human being, a member of the human species which is living.

However, since the Court mandated a sociological criterion, there is now no *legal* criterion for deciding which human lives are to be protected and which are not.

Nothing can be deduced from the Abortion Cases about the limits of the class which is not to be protected. If there are no legal indications, only sociological consensus, then there is literally no human life which cannot ultimately fall victim before such a consensus.

Not all problems which exist in society project a constitutional dimension, nor are all accessible to solution by legal process. It is a fact that many very real social problems do not admit of a legal solution. Furthermore, even those that might yield to a legal solution are not necessarily fit subjects for a constitutional resolution. Here we are faced with a situation in which the Court has chosen to abandon a constitutional mandate to protect human life — a mandate existing through the Fifth and Fourteenth Amendments — in the hope of solving the social problem of women with unwanted pregnancies.

It is surprising that the Court should think so amorphous a condition as unwantedness to be susceptible of solution by judicial adjudication. Instead of readily confronting the fact that the full thrust of its decisions is to prefer some human lives over others, and dealing with the ramifications of such a principle, the Court put before us the notion that it cannot decide when human life begins.

Although the question of when life begins has academic significance, it is unfortunate that so much of the legal controversy surrounding abortion has railed over what is essentially a non-issue. The debate concerns the end of life, not simply the beginning of it. If the process of life has not begun, then what is it that the physician does? Clearly, the "abortion decision" is based on the fundamental understanding between woman and physician that, unless something is done to stop it, a child is going to be born; in each abortion a consensus exists between the woman and her doctor that a life has begun.

It is clear from the foregoing that the concept of viability enunciated in the decision of *Roe v. Wade* involves at once a *de facto* confirmation and a *de jure* denial of the human existence of the unborn child. This is a fundamental contradiction.[2] The rejection of the necessary relation of

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[2]The Federal Rules of Evidence require, pursuant to Rule 201, that only adjudicative facts which are indisputable may be subject for judicial notice. While the federal rules were not in force at the time of the ruling in the Abortion Cases, the doctrine which they express regarding judicial notice was already well established. It is impossible to view the *Roe* decision as not having an adjudicative quality as that holding relates to fetal life. Curiously, the judicial notice taken in *Roe* has all but eliminated the possibility of the "disputed" facts regarding fetal life every becoming an adjudicative concern. See Davis, Judicial Notice, 55 Col. L. Rev. 945, 952 (1955).

fetus to child has placed the Court in an ambiguous posture in relation to "potential life".

The Court in *Roe v. Wade* made an attempt to perceive the societal or normative consensus regarding the quality of life to be recognized as human. The majority there acted on the perception that a "viable" fetus would be accepted as sufficiently "human" to warrant state protection of that life.

The Court's definition of life is not anchored to biology. It is therefore likely that the abandonment of biological life as a criterion of Fifth Amendment protection will continue in the future to place the Court in the position of having to supply frequent and continuing redefinitions of the term "human".

II.

THE PENUMBRA OF PROTECTIONS AFFORDED BY THE BILL OF RIGHTS GUARANTEES A FULL "PERSONHOOD" RIGHT TO THE UNBORN

Coincidental with the Court's rejection of a biological criterion of human life, the majority in *Roe v. Wade* found that the unborn child lacks legal personhood. Legal personhood is not coeval with any "human" characteristics. Legal personhood is and has for some time been recognized in respect to objects such as ships and entities such as corporations which have absolutely *no* potential for ever being "human."

> "The world of the lawyer is peopled with inanimate right-holders; trusts, corporations, joint ventures, municipalities, Subchapter R partnerships, and nation-states, to mention just a few. Ships, still referred to by the courts in the feminine gender, have long had an

> independent jural life, often with striking consequences. We have become so accustomed to the idea of a corporation having 'its' own rights, and being a 'person' and citizen for so many statutory and constitutional purposes, that we forget how jaring the notion was to early jurists. 'That invisible, intangible and artificial being, that mere legal entity' Chief Justice Marshall wrote of the corporation in Bank of the *United States v. Deveau*—could a suit be brought in its name? Ten years later, in the Dartmouth College case, he was still refusing to let pass unnoticed the wonder of an entity 'existing only in contemplation of law.' "[3]

The granting of legal personhood in such instances is, we submit, properly the product of a constitutional analysis which recognizes the existence of rights which must be said to be implicit in other, more explicitly protected rights. The process of analysis which found these rights to reside in the penumbra of others operates on acceptance of a causality which recognizes the force of a necessary implication. The right of property guaranteed in the Constitution carries with it the implication that the causal connection between a business organization and the contractual relationships that flow therefrom imply a legal significance great enough to provide that "invisible" intangible, and artificial being" with legal personhood.

Recognition of the legal significance of such causal implication is not limited to personification of business organizations. The process used to reach the penumbral rights enunciated in *Griswold v. Connecticut*[4] is the self-

[3]Stone, Christopher, *Should Trees Have Standing*, Kaufman, 1972, p. 5.

[4]Griswold v. Connecticut, 381 U.S. 479 (1965).

same recognition of necessary implication. Penumbral rights are, quite simply, those rights which must be recognized because they are necessarily implied in an explicitly protected right.

Essentially positive and creative, this penumbral process has recognized rights such as those in *Maynard v. Hill*,[5] *Meyer v. Nebraska*,[6] *Pierce v. Society of Sisters*,[7] and *Griswold v. Connecticut*,[8] as well as those found in *Loving v. Virginia*,[9] *Skinner v. Oklahoma*,[10]. But this process was harshly rejected by the majority in *Roe v. Wade* when it refused to protect fetal life, even though such life has a necessary, not coincidentally antecedent, connection to the lives of all those "persons" protected by explicit mandate of the Constitution.

There is a curious fact in that one of this Court's most resounding paeons to Mill's essay *On Liberty* should manifest a line of reasoning similar to Mill's theory of cause. The Court's treatment of fetal life is "an empiricism like that of John Stuart Mill, for whom a cause simply is an antecedant, and for whom consequently all knowledge is mere observation of fact, devoid of any apprehension of necessity."[11]

It is ironic that the majority in *Roe* not only failed to use the penumbral process with respect to fetal life, but also misapplied it with respect to the pregnant woman. The right

[5]Maynard v. Hill, 125 U.S. 190 (1888).

[6]Meyer v. Nebraska, 262 U.S. 390 (1923).

[7]Pierce v. Society of Sisters, 268 U.S. 510 (1925).

[8]Griswold, supra, n. 13.

[9]Loving v. Virginia, 388 U.S. 1 (1967).

[10]Skinner v. Oklahoma ex rel Williamson, 316 U.S. 535 (1942).

[11]Collingwood, R.G., *The Idea of Nature*, p. 163.

to life is explicitly protected in the Fifth and Fourteenth Amendments; and, by the penumbral process, this protection properly and necessarily should extend to embrace fetal life. A fetus is not a "different being" from a human being. A human being after birth is the "same being" as before; he or she is merely at a different state of development from his or her fetal stage. A human life is a continuum, not a chain of loosely linked segments, and one's existence is assured at the biological level by the same kinds of internal stimuli and reactions throughout one's temporal development. The human element cannot be divorced from *zoos*. There can be no "human" life without human fetal life.

The Mill-like view of the causal relationships between the unborn child and the born adopted by the *Roe* majority and the Court's concommitant rejection of the biological criterion of life are also accompanied by a rejection of the penumbral process which would lead to the recognition of legal personhood. Can it be said that the liberty of the Fifth and Fourteenth Amendments *necessarily* implies a right to abortion? Implication, it should be noted, is not the same as inference. A thing is implied because of the logical necessity that it be so. Is there really a necessity that liberty encompass a private right to end the life of a human fetus?

III.

PRECIOUS CONSTITUTIONAL RIGHTS, PARTICULARLY THOSE WHICH PROTECT AND DIGNIFY HUMAN LIFE, ARE REMOVED FROM THE POLITICAL ARENA AND EXIST INDEPENDENT OF THE WORKINGS OF POPULAR OPINION.

The Court's use of sociological definitions of "human" must be considered in light of one of the aspects of real genius possessed by the United States Constitution. That document removes certain civil rights from the workings of the popular will. Control over certain matters is taken from the various branches of the United States government and from the states by the Bill of Rights and the Fourteenth Amendment respectively. Chief among these civil rights is the right to life, which must not be taken away without due process of law. Before the Abortion Cases, the right to take a life was, under our constitutional system, presumed to be a public right, exercised only under the most rigid controls of due process. Furthermore, the right is fixed in the Constitution and may not be altered by popular consensus, legislatively manifested or otherwise. Thus, a statute which repealed homicide laws would be unconstitutional since it would remove the protection of life from the public sector and locate it in the private sector. Authority for homicide laws, it should be noted, is not founded on any sociological data relating to homicide; rather, it springs from the constitutional protection of life.

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be subitted to vote; they depend on the outcome of no elections.[12]

Nor, it might be added, on public opinion polls.

The effect of the decisions in *Roe v. Wade* and *Doe v.*

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[12] *West Virginia State Bd. of Ed. v. Barnette*, 319 U.S. 624.

Bolton is to endanger civil rights in precisely the way the Constitution was designed to prevent. These decisions subordinate a protected right to the caprice of societal evaluation. Constitutional guarantees of due process are removed, and a protected right is subjected to an extra-legal system of societal consensus rather than the rigorous and objective test of a biological fact. The popularity of a given norm will govern its applicability to the law. *Roe v. Wade* uniquely opens a protected constitutional right to the workings of the popular will.

It is human life that is guaranteed by the Constitution, not the "quality of life". The determination of "quality" is inherently subjective and involves the overwhelming discretionary authority which has been condemned by this Court in many other instances.

The Roe-Doe majority has acted to alter the subtance of the constitutional guarantees to life by way of a redefinition of the term "human" which restricts that term to those able to pass the muster of "meaningful" life. The Court's rejection of the traditional biological criterion has significantly altered the Fifth Amendment guarantees, to such a point that more than biological life is required to invoke them. The Court's use of the ambivalent and universally subjective term "meaningful" must excite speculation as to how much more might be required to invoke these guarantees. In any event, it is clear that all protected life—including life after birth—is now subject to an inchoate consensus among undefined groups as to what is "human".

IV.

TWENTIETH CENTURY SCIENTIFIC DATA BELIES ANTIQUATED NOTIONS OF "QUICKENING" AND MUST SERVE AS THE STANDARD TO DETERMINE THE NATURE OF UNBORN HUMAN LIFE.

The Court has suggested that women "enjoyed rights" to abortion in common law. How is it possible to extrapolate to such a conclusion from a handful of 300-year-old cases? Despite the Supreme Court's approbation, it is unclear that Professor Means' arguments demonstrate "abortional freedom" to be a common law right. There is a substantial distinction between uneven enforcement of a law and an affirmative right. The motive of this resort to history is unclear. According to Albert Camus in *The Rebel*:

> "... The movement of rebellion is founded on the confused conviction of absolute right which, in the rebel's mind is more precisely the impression that he has 'the right to' ... Rebellion cannot exist without the feeling that somewhere, somehow, one is right." [13]

Perhaps it is curious need that sent Professor Means searching out the past for comfort. Returning from those halcyon days, however, he did not bring with him an integral view of the past as it was. He brought instead a 'past' useful to his pleading, while leaving the rest for others to retrieve.

The classic exposition of this type of historiography was written by Herbert Butterfield. His essay focused on what he dubbed the "Whig Fallacy." In essence, the theme of his work is that:

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[13]Camus, A., *The Rebel*, p. 1.

> "... When we organize our general history by reference to the present we are producing what is really a gigantic optical illusion; and that a great number of the matters in which history is often made to speak with most certain voice, are not inferences made from the past but are inferences made from a particular series of abstractions from the past — abstractions which by the very principle of their origin beg the very questions that the historian is pretending to answer."[14]

The decisions in the Abortion Cases did not show us the past. They only used it. Those, however, who go to the past to use it inevitably succumb to the "pathetic fallacy":

> "It is the result of the practice of abstracting things from their historical context and judging them apart from their context — estimating them and organizing the historical story by a system of direct reference to the present."[15]

Neither Professor Means nor the Court provided a picture of abortion practice during the period to which they refer. Such a history would have to include attendant medical, social, and, yes, even religious practices. This history was not provided. For Professor Means as well as for the Court, the past is slave to the present. This may be effective polemics but it is not history. The historian, in Butterfield's words:

> "...comes to his labours conscious of the fact that he is trying to understand the past for the sake of the past, and though it is true that he can never entirely abstract himself from his own age, it is nonetheless certain that his consciousness of his purpose is a very different one from that of the Whig historian, who tells himself that he is studying the past for the sake of the present. Real historical understanding is not achieved by the subordination of the past to the present, but rather by

[14]Butterfield, H., *The Whig Interpretation of History* (1965), p. 29.

[15]ibid p. 30.

> our making the past our present and attempting to see life with the eyes of another century than our own."[16]

The argument that abortion rights were freer in the past is indeed curious. One is led to wonder why it was made.

What is the nature of this relevancy? Implicit in the argument is the notion that the action of a thirteenth century individual participating in an abortion is somehow relevant to our own time. Is this so? In the first place, the Means argument does not demonstrate that thirteenth century society ever embraced "abortional freedom." Second, it is fallacious to suggest that people of the twentieth century are free to ignore available information and to make judgments on the basis of the actions of a small number of those of the thirteenth century. In short, the relevancy of the Means argument to the abortion debate turns on willingness to ignore differences between our age and the thirteenth century. This is a fundamental error in the common law argument adopted by the Court.

The works of Coke and Bracton did not contemplate twentieth century science. Presumably the Court is not prepared to rely on thirteenth century science; why, then, should it attach particular significance to "quickening?" What is quickening but a measurement, albeit crude, of the development of the unborn child? Surely, the ability to measure has advanced significantly since the thirteenth century. In fact, ability to measure is an important aspect of the advance of all science.

> "Empirical inquiry has been conceived as a process from description to explanation . . . the principal technique in effecting the transition from description to explanation is measurement."[17]

The increased ability to measure has given the twentieth

[16]ibid. p. 16.

[17]Lonegran, B.J.F., *Insight*, p. 164-5.

century man a greater appreciation of life as a continuum. One can study the zygote and know the significance of the genetic package.

Clearly, a full unraveling of a "significant strand of the tangled skein" would have required consideration of twentieth century science. This would have shown that it is no longer possible to separate what an organism is from what, in its later development, it does. Admittedly, *any* position concerning the unborn child necessarily involves important religious and philosophical considerations. However, this is not to say that science may be ignored, especially by a government agency. An unborn child has many characteristics; it becomes, it grows, it continues its many functions until that event known as death. To rely upon scientific standards of the thirteenth century in this matter is unacceptable.

Professor Means' argument is simply not relevant to the abortion debate. Viability and quickening have little to do with a twentieth century scientific conception of the nature of the unborn child.

CONCLUSION

Not only were the abortion cases wrongly decided; it was wrong that they be decided at all. With rare unanimity the community of legal scholars, regardless of their views on the practice of abortion, have commended on the lack of any constitutional nexus in the abortion cases.

Mr. Justice White's observation that the court simply fashioned a new right and announced it, has been recognized as apposite in the legal community.[18] The fundamental difficulty with such activity is that, when the Court acts as a legislature, there is no court. The adjudicative function is both a necessary and a specialized activity within our system. If this court is to function as a legislature, where shall one turn for the adjudication of a dispute? At least one scholar has taken the view that judicial overreaching is simply the usurpation of governmental powers not constitutionally granted to the Court. But, as we suggested above, the matter is not merely a question of what power the court takes unto itself; it is also a question of what powers and responsibility it leaves behind.

This amicus recognizes the difficulty attendant upon reversal of the Abortion Cases and their progeny. *Planned Parenthood v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831, 49

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[18]Bickel, Alexander, The Morality of Consent, (1975) New York, Yale University Press.

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L.Ed.2d 788 (1976) and *Baird v. Bellotti*, 428 U.S. 132, 96 S. Ct. 2857. Nevertheless, we submit that to preserve in decisions which have been wrongly decided and wrongly arrived at can only produce new and greater difficulty.

These issues of life and death cannot be willed away by a determined court. Let us wipe the slate clean and start anew.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,

Appellants,

—v.—

JOHN FRANKLIN, M.D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF FOR *AMICI CURIAE* THE AMERICAN PUBLIC HEALTH ASSOCIATION THE AMERICAN CIVIL LIBERTIES UNION THE PENNSYLVANIA CIVIL LIBERTIES UNION THE WOMEN'S LAW PROJECT

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	xiv
INTEREST OF AMICI	1
SUMMARY OF ARGUMENT	4
ARGUMENT	5
I. SECTION 5(A) IN SUBJECTING DOCTORS TO POSSIBLE CRIMINAL SANCTION FOR ABORTING "MAY BE VIABLE" FETUSES, IS UNCONSTITUTIONALLY VAGUE.	
A. The Governing Law	5
B. The Issue in This Case	11
C. The Pennsylvania Approach to Determining Viability	13
D. Predicating Criminal Santions on the Fact that a Fetus "May Be Viable" is Void for Vagueness.	19
1. Section 5(a) Does Not Provide Adequate Notice of the Scope of its Proscription	22
2. Section 5(a) Impermissibly Inhibits the Exercise of Constitutionally Protected Activity	24

TABLE OF CONTENTS (Continued)

	Page
3. Section 5(a) Vests Local Prosecutors With Uncontrolled Discretion to Prosecute Doctors Performing Second-Trimester Abortions.	25
4. Replacing the "May Be Viable" Standard Would Not Eliminate the Vagueness Problem.	27
II. DOCTORS ARE IMMUNE FROM CRIMINAL PROSECUTION FOR EXERCISING MEDICAL JUDGMENT IN DETERMING WHETHER AND BY WHAT TECHNIQUE TO ABORT A FETUS.	29

TABLE OF AUTHORITIES

Cases	Page
Baird v. Bellotti, 428 U.S. 132 (1976)	3
Barr v, Matteo, 360 U.S. 564 (1959)	32
Beal v. Doe, 432 U.S. 464 (1977).....	3
Butz v. Economou, ___ U.S. ___, 46 U.S.L.W. 4952 (June 29, 1978)	46
Commonwealth v. Edelin, ___ Mass. ___, 359 N.E.2d 4 (1976)	26,31
Connally v. General Construction Co., 269 U.S, 385 (1926)	20
Doe v. Bolton, 410 U.S. 179 (1973)	3,5,6
Floyd v. Anders, 440 F. Supp. 535 (D.S.C. 1977) (Three Judge Court), appeal pending, No. 77-1255 (October Term, 1977).	26
Gregoire v. Biddle, 177 F.2d 579 (2nd Cir. 1949)	32
Hodgson v. Anderson, 378 F. Supp. 1008 (D. Minn. 1974), dismissed for want of jurisdiction sub nom Spannaus v. Hodgson,420 U.S. 903 (1975)	9
Hynes v. Borough of Oradell, 425 U.S. 610 (1976)	27

Cases Continued	Page
Imbler v. Pachtman, 424 U.S. 409 (1976)	33
Keyishian v. Board of Regents, 385 U.S. 589 (1967)	21,25
Lanzetta v. New Jersey, 306 U.S. 451 (1939)	20
Papachristou v. City of Jacksonville, 405 U.S. 156 (1972) ..	21
Pierson v. Ray, 386 U.S. 547 (1967)	33
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)	6,7,8, 9,15, 30,32, 33
Poelker v, Doe, 432 U.S. 519 (1977)	3
Quiroga v. Medical Practice Bd., et al, No. 77-20461 - AA (Circuit Court for County of Ingham, filed 1977)	27
Roe v. Wade, 410 U.S. 113 (1973)	4,5,6, 7,8,24, 31,32, 33
Screws v. U.S., 325 U.S. 91 (1945)	19,29, 32
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State Statutes: Page

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IN THE
SUPREME COURT OF THE UNITED STATES

No. 77-891

FRANK S. BEAL, et al.,

Appellants

v.

JOHN FRANKLIN, M.D., and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees

On Appeal From the United States District Court for the Eastern District of Pennsylvania

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BRIEF FOR THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE AMERICAN CIVIL LIBERTIES UNION, THE PENNSYLVANIA CIVIL LIBERTIES UNION, AND THE WOMEN'S LAW PROJECT AMICI CURIAE

INTEREST OF AMICI*

The American Public Health Association (APHA) is a national non-governmental organization established in 1872. Its objective is

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* Amici have obtained permission to file this brief from counsel for both parties. The letters of consent are on file with the Clerk of the Court.

to protect and promote personal and environmental health. With a membership of over 50,000 health professionals including fifty-one affiliated organizations, it is the largest public health organization in the world. The APHA's primary purpose is to develop a national health policy to provide equitable, low-cost, quality health care for all citizens.

The American Civil Liberties Union (ACLU) is a nationwide, non-partisan organization of more than 200,000 members dedicated to defending the principles embodied in the Bill of Rights to the Constitution. The Pennsylvania Civil Liberties Union is the state affiliate of the ACLU operating in Pennsylvania. In the furtherance of its strong interest in preserving the fundamental right to privacy and reproductive freedom, the ACLU has established a Reproductive Freedom Project.

The Women's Law Project is a non-profit feminist legal organization in Philadelphia, Pennsylvania working for the legal equality and reproductive freedom of women through litigation, public education and research.

Attorneys affiliated with the American Civil Liberties Union represented appellants in Doe v. Bolton, 410 U.S. 179 (1973) and appellees in United States v. Vuitch, 402 U.S. 62 (1971) and Poelker v. Doe, 432 U.S. 519 (1977). The ACLU and its affiliates have also appeared amici on other important reproductive freedom cases in this Court including Baird v. Bellotti, 428 U.S. 132 (1976) and Beal v. Doe, 432 U.S. 464 (1977), the latter with the American Public Health Association.

Amici have a strong interest in the issues presented by this case. They believe that the integrity of doctors' independence in treating the reproductive health needs of their patients is at stake here and that women who cannot rely on their physicians' independent medical judgments in treating them are effectively denied their constitutional rights to reproductive freedom.

SUMMARY OF ARGUMENT

In Roe v. Wade, 410 U.S. 113 (1973), this Court identified fetal viability as a critical point on the biological and philosophical continuum and invested it with legal significance. The viability of a given fetus is, however, merely a predictive medical judgment over which reasonable doctors may, and often do, differ. Since a doctor's medical judgment as to viability carries with it grave legal consequences, amici are deeply concerned with the procedures utilized by the state to attempt to influence both the doctor's decision as to viability and medical techniques predicated upon that decision. Amici believe that in order to assure the integrity of the tri-partite analysis suggested in Roe v. Wade, the decision as to fetal viability must be left to the good faith medical judgment of an attending physician. Accordingly, Pennsylvania's attempt to influence that decision by threatening a physician with criminal punishment under vague and amorphous standards if he or she "wrongly"

diagnoses a fetus as non-viable and utilizes medical techniques consistent with that diagnosis is fundamentally at odds with rights delineated in Roe. It is, amici believe, doctors, not prosecutors, who must identify the amorphous point on the biological and philosophical continuum when viability has been attained. Moreover, such a medical decision, fraught with uncertainty, must be insulated from attempts by the state to prevent a doctor from the good faith exercise of considered medical judgment on the question of viability.

ARGUMENT

I SECTION 5(A), IN SUBJECTING DOCTORS TO POSSIBLE CRIMINAL SANCTION FOR ABORTING "MAY BE VIABLE" FETUSES, IS UNCONSTITUTIONALLY VAGUE.

A. The Governing Law

In Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973), this Court

established a now familiar three stage anaylsis governing the state's right to regulate the decision by a woman to seek -- and the decision by a doctor to perform -- an abortion. During the stage prior to approximately the end of the first trimester of pregnancy, the decision to seek an abortion -- and the doctor's decision to perform an abortion -- are wholly outside the regulatory power of the state.[1] During the first trimester, the wishes of the patient and the medical judgment of the attending physician are the sole operative factors. During the stage subsequent to the

[1] The state's interest is confined to assuring the competence of the physician, Roe v. Wade, supra, at 165, and assuring an informed consent to the abortion by the patients. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 67 (1976). The state cannot require that a first trimester abortion be performed in a hospital, Doe v. Bolton, supra, at 195, or advance approval by a hospital committee, Id. at 195-198, or certificate of two physicians Id. at 199, or consent of a spouse or parent, Planned Parenthood of Central Missouri v. Danforth, supra, at 69, 74.

end of the first trimester but prior to viability, the state may regulate the doctor-patient relationship only to promote the health of the patient. However, such health-related regulations during the previability stage may not unduly interfere with a woman's right to seek a second trimester abortion or with a doctor's obligation to use his or her best medical judgment in determining the medical procedures to be utilized in performing the abortion.[2] Once the fetus has attained viability, the state may, if it chooses, regulate and even proscribe abortion unless, in the good faith exercise of medical judgment, an attending physician deems abortion necessary for the preservation of the life or health of the patient. Thus, even during the post-viability stage, the medical judgment of the attending physician remains the dominant

[2] Roe v. Wade, supra, at 163. In Planned Parenthood of Central Missouri v. Danforth, supra, this Court held unconstitutional a statutory prohibition of saline abortion procedures, finding that it "fail[ed] as a reasonable regulation for the protection of maternal health." Id. at 78.

factor in determining the propriety of and the technique of an abortion. Subject to a medical override where necessary to protect the life or health of the woman, the state's interest in protecting potential life justifies state regulations during the post-viability stage which would never be tolerated in a pre-viability setting.

In Roe, this Court sought to define viability as a medical event which generally occurs between the 24th and the 28th week of pregnancy.[3] In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 63-65, (1976), this Court rejected arguments aimed at translating viability into a legal concept of fixed and universal meaning and, instead, reinforced the role of medical judgment in determining the differing points on a con-

[3] In Roe the Court reviewed the history and different philosophical approaches to the issue of viability, and concluded that a viable fetus is one which is "potentially able to live outside the mother's womb, albeit with artificial aid. Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks. [footnote omitted]" 410 U.S. 113, 160 (1973).

tinuum when viability has been attained.[4] As currently understood by the medical profession, viability is a predictive concept based upon a number of factors calling for the exercise of a doctor's medical judgment. Under current practice, a doctor seeking to determine viability must estimate the gestational age and probable weight of the fetus and, comparing the estimated gestational age and weight with empirical observation records of the survival history of similar fetuses, estimate the likelihood of fetal survival. When such an estimate of possible survival reaches an arbitrary probability level the fetus is deemed medically viable. Such a medical judgment as to viability is subject to at least four variables rendering it inexact in the extreme. First, a doctor's judgment as to gestational age is based upon the menstrual history of the patient

[4] The definition of viability adopted by Missouri in and upheld by this Court in Danforth set viability at "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems," 428 U.S. at 63-64. In Danforth, this Court stressed, noting the parties' agreement, that the determination as to viability "rests with the physician in the exercise of his professional judgment." Id., at 65, n.4.

- a notoriously inexact measuring device.[5] Second, a doctor's judgment as to fetal weight is based on a necessarily inexact estimate of the size and condition of the patient's uterus.[6] Third, the predictive value of the empirical observations on which the judgment is ultimately based is itself open to serious question because of the relatively small statistical sample and the existence of variables which render the prediction highly problematic.[7] Finally, the appropriate level of probablity of survival is itself a subject of substantial disagreement.[8]

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5 National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, United States Department of Health, Education and Welfare, Research on the Fetus, 1975, pp. 11-13; L. Hellman & J. Pritchard, Williams Obstetrics, 199 (14th ed. 1971).

6 L. Hellman & J. Pritchard, op. cit., 238. See also: Brenner, Edelman & Hendricks, A Standard of Fetal Growth for the United States of America, 126 American Journal of Obstetrics and Gynecology 555 (Nov. 1, 1976).

7 Id.

8 There is no standard probability level for survival of the fetus which is accepted throughout the medical community. As testimony at trial indicated, each doctor sets his or her [Footnote continued]

B. The Issue in this Case

In the service of its interest in the potential life of the viable fetus, Pennsylvania enacted § 5(a) which provides:

> Section 5. Protection of Life of Fetus
>
> (a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise the degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to

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[Footnote 8 continued]
own level of fetal viability. Dr. Gerstly testified that a twenty-four week fetus has 2-5% chance of survival. (8a-9a) Dr. Franklin labeled viability the 10% chance of fetal survival at twenty-eight weeks. (180a; 20a). Dr. Keenan testified that a twenty-six week fetus has a 10-30% chance of survival (92a-93a). The probability of a fetal survival necessary to find viability ranged from 2% to 30%.

Also, all of the doctors testified to a margin of error of at least two to four weeks in determining gestational age. Such error is obviously critical to the predictions of fetal survival.

> exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother. [Emphasis supplied][9]

The issue posed by this case is not whether viability is an appropriate standard. Rather, it is who is to decide whether a given fetus has attained viability -- the attending physician in the good faith exercise of his or her medical judgment or a prosecutor and jury in the course of a criminal proceeding. Given the significance of viability as a mixed medico-legal concept, what constraints may Pennsylvania impose upon the free exercise of medical judgment by a physician called upon to determine viability? More precisely, to what extent may Pennsylvania erect a criminal procedure to second-guess a physician who has reached a medical judgment that a fetus is not viable and has proceeded to abort it on that assumption?

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[9] Section 5(d) subjects doctors to civil and criminal liability for failure to comply with Section 5(a).

Unfortunately, appellants have not addressed the issue of who decides viability, electing instead to argue a false issue not presented in this case and not opposed by amici. Appellants argue at length that the state possesses an interest in preserving the potential life of a viable fetus, and in seeking to advance that interest, may require the use of certain techniques when a viable fetus is aborted. However, in casting the argument in this form, appellants have begged the basic question by assuming that a given fetus is viable. Before one can debate the consequences of viability, one must determine who is to decide when viability has been attained and extent to which that medical decision may be second-guessed in a criminal proceeding. It is the position of amici that the good faith medical judgment of the attending physician is the sole determinant of viability and that such a good faith judgment may not constitutionally be subject to de novo review in a criminal proceeding.

C. The Pennsylvania Approach to Determining Viability

Pennsylvania recognizes, as it must, that any medical determination concerning viability late in the second trimester of pregnancy is inherently problematic. Accordingly, it

substitutes another concept - "may be viable" - and predicates its attempt to control the medical judgment of attending physicians upon it. Under the Pennsylvania statute, whenever a fetus may be viable, an attending physician is directed to use certain medical techniques to abort it, despite his or her best medical judgment that the fetus is in all likelihood not viable and despite the fact that, left to an unhampered exercise of medical judgment, the doctor would have elected a different medical technique.[10] Moreover, under the Pennsylvania statute, any doctor who reaches a good faith medical decision that a fetus is not viable after mid-pregnancy and acts

[10] The expansion effected by substituting "may be viable" for "viable" is, of course, enormous. Every diagnosis of the viability of a fetus at or shortly after mid-pregnancy involves a physician in a delicate predictive judgment based on a series of inexact factors discussed, supra, at pp. 10-11. Given the essentially statistical nature of the concept, no diagnosis involving viability is ever anything more than an educated guess. In many cases in which a doctor ventures an educated guess that the fetus is not viable, a degree of doubt exists and the fetus could arguably qualify as "may be viable." Certainly, doctors could not afford to risk a criminal prosecution based upon such a vague and all encompassing standard.

accordingly, renders himself liable to criminal prosecution at the hands of a prosecutor who may allege that the doctor erred in deciding the viability issue.[11]

There are many reasons why doctors prefer mid-trimester abortion techniques inconsistent with preservation of fetal life. Saline instillation, although usually fetal destructive, is the most frequently used and among the safest second trimester procedures.[12] On the other hand,

[11] In a particular case it may be much easier to establish that a particular fetus was, or may have been viable, after the fact of abortion than it is to estimate this fact before an abortion. After an abortion, the size of the fetus is precisely knowable, where it is not before. A post-abortion pathology report will produce further data that, for obvious reasons, is not available to the doctor making a judgment whether a pregnant woman carries a fetus which is or may be viable. All of this information, which in the nature of things is not fully available to the physician at the time when he or she must make a decision as to likely viability, will be available to the prosecutor. Under the Pennsylvania statute criminal liability can be established if the prosecutor, with the benefit of hindsight, can show only that a fetus might have been viable.

[12] Planned Parenthood of Central Missouri v. Danforth, supra at 77, W. Cates, K. Schulz, D. Grimes and C. Tyler Abortion Methods: Morbidity Costs and Emotional Impact. 1. The

(footnote 12 cont. on next page)

Prostaglandins, which preserve the fetus, are contraindicated for many women.[13] A hysterotomy although preserving the fetal life, is major surgery involving risks to a woman greater than those of salines or even prostaglandins.[14] Among other considerations, the skill of the physician is an important factor in choice of method for mid-trimester abortions. For example, while there is strong evidence that of the common second trimester methods the D&E (Dilation and Evacuation) is the safest abortion procedure, at the present time few physicians in the entire country are properly

(footnote 12 cont. from previous page)

Effect of Delay and Method of Choice on the Risk of Abortion Morbidity. 9 Family Planning Perspectives 266 (1977) (hereinafter, Cates et al., Effect of Delay)

13 For example, women with pre-existing medical conditions such as asthma, glacoma, hypertension, cardiovascular disease or epilepsy are poor prostagladin risks. Also it should not be used in the presence of acute pelvic inflamatory disease. Some women will be hypersensitive to the drug itself, Wynn v. Scott, No. 75 C-3975 (Eastern District of Illinois, April 12, 1978) (Three-Judge Court) Slip op. 63-64.

14 Cates et al., Effect of Delay at 268. Infection and hemorrhage occur in 35-45% of the cases (Tr. 73a).

trained to perform the procedure. As training and expertise increase, however, D&E will undoubtedly become a far more common method.[15] In short, amici believe that § 5(a) flies in the face of current medical knowledge on the subject of second trimester abortions by apparently mandating use of methods which are known to be the most dangerous to the woman's health. It is clear that as medical science continues to research and refine methods of performing mid-trimester abortions the gap between procedures contemplated by § 5(a) and the methods urged by doctors as the safest for their patients will grow wider rather than

15 Statement by Dr. Willard Cates, Center for Disease Control at a Conference on Alternative Procedures for Mid-Trimester Abortions as reported in Female Health Topics and Diagnostic Reporter Vol. I No. 1 (1978) at 4 col. 1. The total morbidity rate for D&E's at seventeen weeks or later is 5.38 per 100 legal abortions, compared to 35.87 for salines and 51.08 for Prostaglandins. Cates et al., Effect of Delay at 267. Another advantage of the D&E procedure is that it does not require a waiting period between the thirteenth and fifteenth weeks of gestation. Delay in obtaining the abortion has been found to be a critical factor in maternal morbidity. Cates et al., Effect of Delay, supra.

narrower.[16]

The net result of the Pennsylvania statute is to dictate the technique to be used in aborting a mid-pregnancy fetus, despite the judgment of the attending physician that the fetus is not viable and should be aborted pursuant to a different technique. Moreover, under the Pennsylvania statute, a doctor who diagnoses a mid-pregnancy fetus as non-viable

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[16] The issue of alternative procedure of second trimester abortion is currently the subject of serious debate within the medical community. In March, 1978, the American College of Obstetricians and Gynecologists and several other medical societies sponsored a conference on the issue of alternative methods of second trimester abortions at which Dr. Willard Cates, of HEW's Center for Disease Control, Bureau of Epidemiology Family Planning Evaluation noted a shift over time in methods, reflecting increased use of D&E over prostaglandins. Alternative Procedures, 1 Female Health Topics & Diagnostics Reporter, at 4, col 3. Dr. Cates suggested that the results of the latest studies conducted by CDC and the Joint Program for Study on Abortion (JPSA) challenge the wisdom of traditional practices regarding second trimester abortions. "We are calling into question the 12-week gestational age limit on abortions by uterine curettage procedures." Id., col. 4.

and utilizes an abortion technique not in favor with the local authorities, risks a criminal prosecution in which the doctor will have the impossible burden of demonstrating that the fetus was not even arguably viable.

D. Predicating Criminal Sanctions on the Fact that a Fetus "May Be Viable" is Void for Vagueness

In threatening doctors with potential criminal sanctions if they diagnose a fetus non-viable after the middle of the second trimester when a prosecutor believes that the fetus may have been viable, the Pennsylvania statute violates basic constitutional norms.

Pennsylvania predicates potential criminal sanctions on a finding that a fetus "may be viable." Were the Pennsylvania statute to predicate liability on the improper abortion of a viable fetus, serious vagueness issues would be raised by the inherently inexact nature of viability as a medical concept.[17]

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[17] The vagueness inherent in a statute predicated on viability is discussed infra at 27-29. Briefly put, amici believes that absent a requirement of scienter, doctors may not be prosecuted for aborting a fetus alleged to be viable. So long as a doctor does not intentionally and willfully violate a viability based statute, he should remain immune from prosecution. Cf. Screws v. United States,

(footnote 17 cont. on next page)

However, Pennsylvania has vastly exacerbated the vagueness problem by predicating criminal liability on the improper abortion of a fetus which "may be viable." When a concept is as devoid of objective meaning as "may be viable," it cannot serve as the standard for imposing criminal liability.

This Court has recognized three basic policies which are served by the void-for-vagueness doctrine. First, vague criminal statutes offend procedural due process of law by failing to afford proper notice to an accused of the scope and nature of the proscription at issue. E.g., Connally v. General Construction Co., 269 U.S. 385, 391 (1926); Lanzetta v. New Jersey, 306 U.S. 451 (1939); Smith v. Goguen, 415 U.S. 566 (1974). Second,

[Footnote 17 continued]
325 U.S. 91 (1945). Since there is no requirement of specific wrongful intent in the Pennsylvania statute, a doctor may be held criminally liable for a judgment that simply may have been wrong, as well as for one which is shown to have been made in bad faith. Appellants in their argument to this Court, attempt to confuse the issue by stating that if the judgment of the court below is affirmed doctors will be free to make unreasonable determinations of non-viability "cavalierly, wrongfully and without fear of consequence." Brief of the Appellants, p. 32.

vague criminal statutes deter law-abiding citizens from engaging in conduct which may be construed as falling within the coverage of the vague law. When such deterred conduct is itself constitutionally protected, the "chilling effect" of a vague proscription is deemed an unacceptable price to pay. Eg. Keyishian v. Board of Regents, 385 U.S. 589 (1967). Finally, vague criminal statutes fail to provide enforcement officials with adequate guidance concerning the precise scope of the proscribed activity, vesting such officials with excessive discretion to prosecute disfavored defendants. Eg., Papachristou v. City of Jacksonville, 405 U.S. 156 (1972). See generally, Amsterdam, The Void-for-Vagueness Doctrine in the Supreme Court, 109 U. Pa. L. Rev. 67 (1960). Pennsylvania's decision to cause potential criminal prosecution of a doctor to turn on a determination of whether a fetus "may be viable" violates all three aspects of the void-for-vagueness doctrine.

1. Section 5(a) Does Not Provide Adequate Notice of the Scope of Its Proscription

As amicus has noted, the concept of viability is itself an elusive and inexact predictive point on the biological and philosophical continuum. See, supra at 9-10. It is, however, a concept with a minimal kernel of intrinsic meaning. In contrast, the concept "may be viable" is utterly without objective meaning. See, supra, at n. 8 . What percentage of probability must a doctor project to decide, not that a fetus is viable, but that it "may be viable?" No doctor, confronted with the command of Section 5(a), can know with any reasonable degree of certainty whether a given fetus -- diagnosed as non-viable in the doctor's best medical judgment -- must, under pain of criminal prosecution, nevertheless be dealt with as a fetus which "may be viable."

In Smith v. Goguen, 415 U.S. 566 (1974), this Court invalidated a Massachusetts statute making it a crime to "treat contemptuously" the flag of the United States. In condemning the "treats contemptuously" standard, Mr.

Justice Powell, writing for the Court, noted:

> This criminal provision is vague "not in the sense that it requires a person to conform his conduct to an imprecise but comprehensible normative standard, but rather in the sense that no standard of conduct is specified at all." [citation omitted.] Such a provision simply has no ascertainable standard for inclusion and exclusion is precisely what offends the Due Process Clause. 415 U.S. at 578 [Emphasis in original].

Since the concept "may be viable" likewise provides no "comprehensible normative standard" it may not found the basis for the criminal prosecution of a doctor.[18]

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[18] Appellants' belated attempt to jettison the amorphous concept of "may be viable" by asking this Court to strike it is, of course, unavailing. Brief of Appellants, p. 43. This Court is without authority to construe away a constitutional infirmity in a state statute. E.g., Smith v. Goguen, 415 U.S. 566, 575 (1974); United States v. Thirty-Seven Photographs, 402 U.S. 363, 369 (1971). Moreover, appellants' request to strike the "may be viable" language from Section 5(a) is not a request for judicial construction, but for judicial re-writing. See, e.g., Welsh v. United States, 398 U.S. 333, 344 (1970) (Harlan, J. concurring).

2. Section 5(a) Impermissibly Inhibits the Exercise of Constitutionally Protected Activity

Roe v. Wade, supra, contemplates the exercise of a constitutionally protected right to a pre-viability abortion throughout the second trimester of pregnancy. To the extent the vagueness inherent in the "may be viable" standard inhibits doctors from performing late second trimester abortions because they justifiably fear entanglement in the amorphous web spun by Section 5(a), the right of a woman to obtain a second trimester abortion is seriously compromised. Since any fetus past mid-pregnancy is a candidate for coverage under the "may be viable" standard, the impact of Section 5(a) is to deter physicians from becoming involved in late second trimester abortions. Even if a physician is prepared to undertake a late second trimester abortion under the often hostile gaze of the local prosecutor, he must subordinate his medical judgment concerning viability to the directive of the statute and tailor his medical techniques accordingly, or risk criminal prosecution. The net result of the statute, therefore, is an interference with the free exercise of

medical judgment and a corresponding decline in the ability of a woman to receive the medical guidance to which she is entitled under Roe.

This Court has consistently invalidated amorphous criminal statutes which inhibit the free exercise of constitutionally protected activity. Eg. Keyishian v. Board of Regents, 385 U.S. 589 (1967). Statutes, such as Section 5(a), which require persons to speculate at their peril whether they may engage in constitutionally protected activity cast an impermissible pall upon the free exercise of constitutional rights.[19]

3. Section 5(a) Vests Local Prosecutors With Uncontrolled Discretion to Prosecute Doctors Performing Second Trimester Abortions

Since virtually all mid-pregnancy fetuses qualify as possible candidates for coverage

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19 While speculation concerning legislative motivation is always difficult [Compare Washington v. Davis, 426 U.S. 229 (1976) with United States v. O'Brien, 391 U.S. 367 (1968)], it is probable that the prime purpose of Section 5(a) is to deter doctors from performing late second trimester abortions.

under a "may be viable" standard, the effect of Section 5(a) is to render vulnerable to prosecution any physician who performs a late second trimester abortion on a fetus diagnosed by the doctor as non-viable. In order to invoke Section 5(a) against such a doctor, a prosecutor need do no more than demonstrate that the aborted fetus fell within the extremely broad range of possible, rather than actual, viability. Such an uncontrolled power, especially in the highly polarized and emotional area of abortion, is nothing less than an invitation to a local prosecutor to treat a doctor as a medical pawn in the political struggle over abortion.[20]

As Mr. Justice Powell noted in Smith v. Goguen, supra, statutes, such as Section 5(a), which vest local officials with uncontrolled discretion to invoke the criminal process against ideological opponents cannot survive

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[20] Unfortunately, the recent literature abounds with attempts by ambitious and ideologically motivated prosecutors to use the criminal prosecution of a doctor as a technique to inhibit abortion. Cf., U.S. v. Vuitch, 402 U.S. 62 (1971); Floyd v. Anders, 440 F.Supp. 535 (D. S.C. 1977) (Three-Judge Court), appeal pending, No. 77-1255 (Oct. Term 1977); Commonwealth v. Edelin, ___ Mass. ___, 359 N.E.2d 4 (1976): State v. Munson, 86 S.D. 663, [Footnote continued]

constitutional scrutiny. See also, e.g., Hynes v. Borough of Oradell, 425 U.S. 610 (1976).

4. Replacing the "May Be Viable" Standard Would Not Eliminate the Vagueness Problem.

Appellants, recognizing the hopeless vagueness of the "may be viable" standard adopted by Section 5(a), have requested this Court to re-write the statute by substituting a standard based on actual, rather than possible, viability. As amici have noted, appellants' attempt to jettison the "may be viable" standard cannot save the Pennsylvania statute at

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[Footnote 20 Continued]
201 N.W.2d 123 (1972) (directed verdict for defendant); Dr. Pablo Quiroga v. Medical Practice Bd., et al., No. 77-20461-AA (Circuit Court for County of Ingham, filed 1977). Other prosecutorial attempts have failed to result in indictments. A coroner's inquest was held in Pittsburgh during October and November 1974 to investigate a charge that Dr. Leonard Laufe, chief of obstetrics at Western Pennsylvania Hospital, had murdered an aborted fetus by allowing it to die after it survived an abortion. New York Times, October 31, 1974 at 27, col. 2. The coroner's jury concluded that the fetus had been stillborn and cleared Dr. Laufe of the charge, Id., November 8, 1974 at 45, col. 7. In June, 1974 a Minneapolis grand jury cleared the University of Minnesota Hospital and staff of the charge that fetuses which survived abortions were allowed to die.

issue in this case, since this Court lacks power to construe, much less re-write, an unconstitutional state statute. E.g.,United States v. Thirty-Seven Photographs, 402 U.S. 363, 369 (1971); Smith v. Goguen, 415 U.S. 566, 575 (1974). Thus, strictly speaking, no issue is raised in this case concerning the constitutionality of a statute similar to Section 5(a) predicated on the actual as opposed to the possible viability of a fetus. However, amici suggest that, given the inherent inexactitude of the predictive medical concept of viability and given the shifting and obscure factors upon which a diagnosis of viability rests, even a statute which purports to regulate medical techniques utilized in the abortion of a viable fetus would raise similar, though less extreme, issues of vagueness. Indeed, amici suggest, in the absence of a scienter requirement, any

[Footnote 20 Continued]
Minneapolis Tribune, June 5, 1971 at 1, col. 2, as cited in Sendor, Medical Responsibility for Fetal Survival Under Roe and Doe, 10 Harvard Civil Rights - Civil Liberties Law Review 444 (1975). See also Woman's Right, Physician's Judgment: Commonwealth v. Edelin and a Physician's Criminal Liability for Fetal Manslaughter 4 Women's Rights Law Reporter 97 (1978).

attempt to impose criminal sanctions on a doctor on the basis of an ex post facto finding that the "wrong" technique was used to abort an allegedly viable fetus would be doomed to failure under the vagueness doctrine. If Sheriff Screws was entitled as a matter of due process of law to require the prosecution to prove scienter when he beat his prisoner to death, surely a doctor, who performs an abortion on the good faith assumption that a fetus is not viable, is entitled to a similar protection Cf., Screws v. United States, 325 U.S. 91 (1945). Thus, in the absence of a requirement that the prosecution demonstrate a willful and intentional abortion of a fetus believed by the doctor to be viable, the state is disabled from second guessing an attending physician by subjecting him to criminal prosecution for improperly aborting a viable fetus. Commonwealth v. Edelin, supra.

II DOCTORS ARE IMMUNE FROM CRIMINAL PROSECUTION FOR EXERCISING MEDICAL JUDGMENT IN DETERMINING WHETHER AND BY WHAT TECHNIQUE, TO ABORT A FETUS

In the area of abortion, this Court has delegated to the medical profession at least two vital decisions fraught with legal implications. First, this Court has insisted that the decision as to the viability of a given fetus be made by individual attending physicians in the best exercise of their medical judgment. Planned Parenthood of Missouri v. Danforth, supra. The diagnosis of the attending physician as to viability is then permitted by this Court to trigger radically different legal consequences. Second, this Court has insisted that, even during the post-viability phase, the attending physician be permitted to abort a viable fetus when he or she determines such a procedure to be necessary to preserve the life or health of the patient. Such a post-viability diagnosis, once again, is permitted by this Court to give rise to dramatically differing legal rights and obligations. In exercising the medical skill necessary to reach a predictive judgment as to viability or a diagnostic judgment as to the threat to a patient's life or health, doctors have been directed by this Court to engage in a mixed medico-legal activity requiring the highest degree of professional skill. As with so many other difficult judgments in our society, however,

reasonable doctors may and, often, do disagree about a given prediction or diagnosis.[21] In medicine, as in law, predictive and diagnostic judgments do not lend themselves to objective determinations of right and wrong. Accordingly, if individual doctors are to be free to carry out the responsibilities placed upon them by Roe v. Wade, attending physicians must be insulated from threats of criminal prosecutions based upon an allegation that the doctor's diagnosis was wrong. Amici believe that so long as a doctor exercises medical judgment in attempting to predict viability or diagnose post-viability dangers to a patient's life or health, actions taken by a doctor in accordance with his or her medical judgment cannot found the basis of criminal liability. Whether one phrases the insulation concept as a common law

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21 Disagreements over medical judgments in the abortion area are likely to be more pronounced since the area implicates deeply felt religious and ethical values. The biological factors are difficult enough to assess without viewing them through ideological prisms.

immunity, as in Stump v. Sparkman, ___ U.S. ___, 46 U.S.L.W. 4253 (March 28, 1978); a scienter requirement, as in Screws v. United States, supra; an interference with the right of a doctor to practice his profession, cf. Planned Parenthood of Central Missouri v. Danforth, supra; United States v. Vuitch, 402 U.S. 62 (1971); or a necessary corollary of the structure established by Roe v. Wade, attending physicians must be immune to a threat of retrospective sanction arising out of a good faith exercise of medical judgment.

This Court is no stranger to the fact that it is occasionally necessary to immunize persons vested with delicate decision-making responsibilities from threat of retrospective sanction in order to assure the unhampered exercise of judgment. See generally, Barr v. Matteo, 360 U.S. 564 (1959); Gregoire v. Biddle, 177 F.2d 579 (2d Cir. 1949). Thus, in Stump v. Sparkman, supra, this Court ruled that a judge was absolutely immune from civil liability for issuing an ex parte sterilization order in blatant excess of his jurisdiction. If the free exercise of judicial decision-making requires the insulation of a judge from the consequences of a

wrongful sterilization order, surely the free exercise of the delicate medical judgments demanded of doctors under Roe v. Wade and Planned Parenthood v. Danforth, calls for a similar insulation from the threat of criminal liability. See also, Pierson v. Ray, 386 U.S. 547 (1967) (judicial immunity extendes to bad faith acts).

In Imbler v. Pachtman, 424 U.S. 409 (1976), this Court ruled that prosecutor was absolutely immune from civil liability for the knowing use of perjured testimony in a criminal proceeding. If the free exercise of prosecutorial decision-making requires the insulation of a prosecutor from the consequences of his knowing use of perjured testimony, surely the free exercise of the delicate medical judgments demanded of doctors under Roe v. Wade and Planned Parenthood v. Danforth, calls for a lesser insulation from a threat of criminal sanction for the good faith exercise of medical judgment.

Even in areas in which this Court has declined to recognize absolute immunity, it has recognized that individuals vested with decision-making responsibilities in uncertain areas

may not be punished for a decision which they believed, in good faith, to be correct. E.g., Butz v. Economou, ___ U.S. ___, 46 U.S.L.W. 4952 (June 29, 1978); Wood v. Strickland, 420 U.S. 308 (1975). Doctors are entitled, at a minimum, to the same qualified immunity in carrying out the judgmental responsibilities imposed upon them by this Court in the area of abortion.

CONCLUSION

Since Section 5(a) adopts a standard of criminal liability devoid of objective meaning and since doctors are entitled to a degree of immunity in carrying out their judgmental responsibilities, the decision of the District Court should be affirmed.*

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